

# MEDICAL HISTORY

Patient Name: \_\_\_\_\_ Birthday: \_\_\_\_\_ Nickname: \_\_\_\_\_

Are you under a physician's care now? Y N Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Have you ever been hospitalized or had a major operation? Y N Details \_\_\_\_\_

Are you taking any medications or pills? Y N Please list medications: \_\_\_\_\_

Do you take, or have you taken Phen-Fen or Redux? Y N

Do you use tobacco? Y N

Are you pregnant? Y N Nursing? Y N Taking oral contraceptives? Y N

Are you allergic to any drugs or medications? Y N Please list: \_\_\_\_\_

Have you ever been diagnosed with: Congenital Heart Defect? Y N

Rheumatic Heart Disease or Damage? Y N

Heart Murmur? Y N

Mitral Valve Prolapse? Y N

High Blood Pressure? Y N

Have you ever been told you need to take antibiotics prior to going to the dentist? Y N

Are you taking Blood Thinners (coumadin)? Y N Please list: \_\_\_\_\_

Do you have, or have you had any of the following?

- |                                                    |                                             |                                                |                                                 |                                              |
|----------------------------------------------------|---------------------------------------------|------------------------------------------------|-------------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> AIDS/HIV Positive         | <input type="checkbox"/> Chest Pains        | <input type="checkbox"/> Frequent Headaches    | <input type="checkbox"/> Irregular Heartbeat    | <input type="checkbox"/> Scarlet Fever       |
| <input type="checkbox"/> Alzheimer's Disease       | <input type="checkbox"/> Cold Sores         | <input type="checkbox"/> Genital Herpes        | <input type="checkbox"/> Kidney Problems        | <input type="checkbox"/> Shingles            |
| <input type="checkbox"/> Anaphylaxis               | <input type="checkbox"/> Heart Defect*      | <input type="checkbox"/> Glaucoma              | <input type="checkbox"/> Leukemia               | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Anemia                    | <input type="checkbox"/> Convulsions        | <input type="checkbox"/> Hay Fever             | <input type="checkbox"/> Liver Disease          | <input type="checkbox"/> Sinus Trouble       |
| <input type="checkbox"/> Angina                    | <input type="checkbox"/> Cortisone Meds     | <input type="checkbox"/> Heart Attack/Failure  | <input type="checkbox"/> Low Blood Pressure     | <input type="checkbox"/> Spina Bifida        |
| <input type="checkbox"/> Arthritis/Gout            | <input type="checkbox"/> Diabetes           | <input type="checkbox"/> Heart Murmur*         | <input type="checkbox"/> Lung Disease           | <input type="checkbox"/> Stomach Disease     |
| <input type="checkbox"/> Artificial Heart Valve*   | <input type="checkbox"/> Drug Addiction     | <input type="checkbox"/> Heart Pacemaker*      | <input type="checkbox"/> Mitral Valve Prolapse* | <input type="checkbox"/> Stroke              |
| <input type="checkbox"/> Artificial Joint*         | <input type="checkbox"/> Easily Winded      | <input type="checkbox"/> Heart Trouble/Disease | <input type="checkbox"/> Pain in Jaw Joints     | <input type="checkbox"/> Swelling of Limbs   |
| <input type="checkbox"/> Asthma                    | <input type="checkbox"/> Emphysema          | <input type="checkbox"/> Hemophilia            | <input type="checkbox"/> Parathyroid Disease    | <input type="checkbox"/> Thyroid Disease     |
| <input type="checkbox"/> Blood Disease             | <input type="checkbox"/> Epilepsy/Seizures  | <input type="checkbox"/> Hepatitis A           | <input type="checkbox"/> Psychiatric Care       | <input type="checkbox"/> Tonsillitis         |
| <input type="checkbox"/> Blood Transfusion         | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Hepatitis B or C      | <input type="checkbox"/> Radiation Treatments   | <input type="checkbox"/> Tuberculosis        |
| <input type="checkbox"/> Breathing/Airways Problem | <input type="checkbox"/> Excessive Thirst   | <input type="checkbox"/> Herpes                | <input type="checkbox"/> Recent Weight Loss     | <input type="checkbox"/> Tumors or Growths   |
| <input type="checkbox"/> Bruise Easily             | <input type="checkbox"/> Fainting/Dizziness | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Renal Dialysis         | <input type="checkbox"/> Ulcers              |
| <input type="checkbox"/> Cancer                    | <input type="checkbox"/> Frequent Cough     | <input type="checkbox"/> Hives or Rash         | <input type="checkbox"/> Rheumatic Fever*       | <input type="checkbox"/> Venereal Disease    |
| <input type="checkbox"/> Chemotherapy              | <input type="checkbox"/> Frequent Diarrhea  | <input type="checkbox"/> Hypoglycemia          | <input type="checkbox"/> Rheumatism             | <input type="checkbox"/> Yellow Jaundice     |

Have you ever had any serious illness not listed above? Y N \_\_\_\_\_

Do you have any questions about your medical history? Y N \_\_\_\_\_

To the best of my knowledge, the questions answered on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent, or Guardian

Date

# JONATHAN P. MONTAG D.D.S.

## FINANCIAL ARRANGEMENTS

### All patients, please read the following...

Payment, or estimated co-payment for services is expected at the time service is provided. If treatment requires multiple appointments, payment may be divided over the number of appointments. Cash, personal checks, Visa, and MasterCard, and Discover are accepted. If an extended payment plan is desired, please ask us about the Capital One financing program.

### If you have dental insurance...

As a courtesy, we will electronically file your claim for you. We may accept direct payment from some insurance companies. We will estimate your deductible and the portion not covered by your insurance, which is due at the time of treatment. Our estimates may be different than your insurance company's calculations; therefore, the amount due our office may be adjusted accordingly. In certain cases your insurance company will not send our office your insurance check. In these cases, payment in full is expected at the time of service and your insurance reimbursement will be sent directly to you. As a service to you, we will file your claim electronically and your reimbursement usually arrives within 2-4 weeks. You may find that our fees may be different from the insurance company's schedule of "allowable" or "UCR" fees. If you have questions about "UCR" fees, please feel free to ask. All services rendered are charged directly to the patient, and the patient is ultimately responsible for the account regardless of insurance coverage. Any insurance claims denied or remaining unpaid after 60 days will automatically become the responsibility of the patient.

I understand and agree that all services rendered me, my dependents, or others assigned by me to my account are ultimately my responsibility. If I suspend or terminate care and treatment, any fees for services rendered will be immediately due and payable. Should the fees for the professional services not be paid in accordance with the provisions herein, reasonable attorney's fees, plus applicable finance charges and disbursements, allowances and costs provided by law shall be included in the computation of the amount due. Finance charges can be applied to all past due amounts at the rate of 1.5% per month (18% annual rate). If the account is in default and turned over for collection, a collection fee will be added.

### Cancellation Policy...

I understand that 2 business days notice is required for all cancelled or moved appointments. Dr. Montag reserves the right to charge a fee of \$75 for each hour of chair time lost due to a missed appointment without at least 2 business days notice.

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Print Name

Signature & Date

**JONATHAN P. MONTAG D.D.S.**

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE  
OF PRIVACY PRACTICES**

**\*\*You may refuse to sign this acknowledgement\*\***

I, \_\_\_\_\_ have received a copy of this office’s Notice of Privacy Practices.

\_\_\_\_\_

please print name

\_\_\_\_\_

signature

\_\_\_\_\_

date

**FOR OFFICE USE ONLY**

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- individual refused to sign
- communications barriers prohibited obtaining the acknowledgement
- an emergency situation prevented us from obtaining acknowledgement
- other (please specify)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## New Patient Information

Name \_\_\_\_\_ Birthday \_\_\_\_\_ S.S.# \_\_\_\_\_

Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell \_\_\_\_\_

Email Address \_\_\_\_\_

Reason for Visit: \_\_\_\_\_

When was your last dental visit? \_\_\_\_\_ Purpose? \_\_\_\_\_

When was your last set of complete xrays taken? \_\_\_\_\_

Who was your previous dentist? \_\_\_\_\_

How did you hear about Dr. Montag? \_\_\_\_\_

Are you in pain? Y N

Describe \_\_\_\_\_

Have you ever been told that you have a heart murmur, mitral valve prolapse, rheumatic fever, or any other condition that would require taking antibiotics prior to a dental visit??

Please circle: Y N -- if Yes, please explain \_\_\_\_\_

Do you have any artificial joints? Y N -- if Yes, where? \_\_\_\_\_

Do you or have you been told that you grind your teeth? Y N

Are you satisfied with the appearance of your teeth? Y N -- if NO, please explain

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you ever had an upsetting experience in the dental office?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you have any special questions or concerns to discuss with Dr. Montag?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_