

# Health History Form

Email: \_\_\_\_\_ Today's Date: \_\_\_\_\_

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: <i>Last First Middle</i>			Home Phone: <i>Include area code</i> ( )		Business/Cell Phone: <i>Include area code</i> ( )				
Address: <i>Mailing address</i>			City:		State: Zip:				
Occupation:			Height:		Weight:				
			Date of Birth:		Sex: M F				
SS# or Patient ID:		Emergency Contact:		Relationship:		Home Phone: <i>Include area code</i> ( )			
						Cell Phone: <i>Include area code</i> ( )			
If you are completing this form for another person, what is your relationship to that person?									
<i>Your Name</i>				<i>Relationship</i>					
<b>Do you have any of the following diseases or problems:</b>				<i>(Check DK if you Don't Know the answer to the the question)</i>				<b>Yes No DK</b>	
Active Tuberculosis.....								□ □ □	
Persistent cough greater than a 3 week duration.....								□ □ □	
Cough that produces blood.....								□ □ □	
Been exposed to anyone with tuberculosis.....								□ □ □	
<b>If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.</b>									

## Dental Information *For the following questions, please mark (X) your responses to the following questions.*

<b>Yes No DK</b>			<b>Yes No DK</b>		
Do your gums bleed when you brush or floss?..... □ □ □			Do you have earaches or neck pains?..... □ □ □		
Are your teeth sensitive to cold, hot, sweets or pressure?..... □ □ □			Do you have any clicking, popping or discomfort in the jaw?..... □ □ □		
Is your mouth dry?..... □ □ □			Do you brux or grind your teeth?..... □ □ □		
Have you had any periodontal (gum) treatments?..... □ □ □			Do you have sores or ulcers in your mouth?..... □ □ □		
Have you ever had orthodontic (braces) treatment?..... □ □ □			Do you wear dentures or partials?..... □ □ □		
Have you had any problems associated with previous dental treatment?..... □ □ □			Do you participate in active recreational activities?..... □ □ □		
Is your home water supply fluoridated?..... □ □ □			Have you ever had a serious injury to your head or mouth?..... □ □ □		
Do you drink bottled or filtered water?..... □ □ □			Date of your last dental exam:		
If yes, how often? <i>Circle one:</i> DAILY / WEEKLY / OCCASIONALLY			What was done at that time?		
Are you currently experiencing dental pain or discomfort?..... □ □ □			Date of last dental x-rays:		
What is the reason for your dental visit today?					
How do you feel about your smile?					

## Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

<b>Yes No DK</b>			<b>Yes No DK</b>		
Are you now under the care of a physician?..... □ □ □			Have you had a serious illness, operation or been hospitalized in the past 5 years?..... □ □ □		
Physician Name: _____ Phone: <i>Include area code</i> ( )			If yes, what was the illness or problem?		
Address/City/State/Zip:			Are you taking or have you recently taken any prescription or over the counter medicine(s)?..... □ □ □		
Are you in good health?..... □ □ □			If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements:		
Has there been any change in your general health within the past year?..... □ □ □			_____		
If yes, what condition is being treated?			_____		
Date of last physical exam:			_____		

# Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

<p><i>(Check DK if you Don't Know the answer to the question)</i></p> <p>Do you wear contact lenses? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p><b>Joint Replacement.</b> Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Date: _____ If yes, have you had any complications? _____</p> <p>Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax®, Actonel®, Atelvia, Boniva®, Reclast, Prolia) for osteoporosis or Paget's disease? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia®, Zometa®, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Date Treatment began: _____</p>	<p style="text-align: right;"><b>Yes No DK</b></p> <p>Do you use controlled substances (drugs)? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Do you use tobacco (smoking, snuff, chew, bidis)? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>If so, how interested are you in stopping? <i>Circle one: VERY / SOMEWHAT / NOT INTERESTED</i></p> <p>Do you drink alcoholic beverages? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>If yes, how much alcohol did you drink in the last 24 hours? _____</p> <p>If yes, how much do you typically drink in a week? _____</p> <p><b>WOMEN ONLY</b> Are you:</p> <p>Pregnant? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Number of weeks: _____</p> <p>Taking birth control pills or hormonal replacement? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Nursing? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
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<p><b>Allergies.</b> Are you allergic to or have you had a reaction to: To all <b>yes</b> responses, specify type of reaction.</p> <p>Local anesthetics ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Aspirin ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Penicillin or other antibiotics ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Barbiturates, sedatives, or sleeping pills ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Sulfa drugs ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Codeine or other narcotics ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>	<p style="text-align: right;"><b>Yes No DK</b></p> <p>Metals ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Latex (rubber) ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Iodine ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Hay fever/seasonal ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Animals ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Food ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Other ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
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**Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.**

<p style="text-align: right;"><b>Yes No DK</b></p> <p>Artificial (prosthetic) heart valve ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Previous infective endocarditis ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Damaged valves in transplanted heart ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Congenital heart disease (CHD)</p> <p style="padding-left: 20px;">Unrepaired, cyanotic CHD ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p style="padding-left: 20px;">Repaired (completely) in last 6 months ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p style="padding-left: 20px;">Repaired CHD with residual defects ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>	<p style="text-align: right;"><b>Yes No DK</b></p> <p>Autoimmune disease ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Rheumatoid arthritis ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Systemic lupus erythematosus ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Asthma ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Bronchitis ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Emphysema ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Sinus trouble ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Tuberculosis ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Cancer/Chemotherapy/ Radiation Treatment ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Chest pain upon exertion ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Chronic pain ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Diabetes Type I or II ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Eating disorder ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Malnutrition ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Gastrointestinal disease ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>G.E. Reflux/persistent heartburn ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Ulcers ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Thyroid problems ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Stroke ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>	<p style="text-align: right;"><b>Yes No DK</b></p> <p>Glaucoma ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Hepatitis, jaundice or liver disease ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Epilepsy ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Fainting spells or seizures ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Neurological disorders ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p style="padding-left: 20px;">If yes, specify: _____</p> <p>Sleep disorder ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Do you snore? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Mental health disorders ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p style="padding-left: 20px;">Specify: _____</p> <p>Recurrent Infections ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p style="padding-left: 20px;">Type of infection: _____</p> <p>Kidney problems ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Night sweats ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Osteoporosis ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Persistent swollen glands in neck ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Severe headaches/migraines ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Severe or rapid weight loss ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Sexually transmitted disease .. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Excessive urination ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
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*Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.*

<p style="text-align: right;"><b>Yes No DK</b></p> <p>Cardiovascular disease ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Angina ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Arteriosclerosis ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Congestive heart failure ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Damaged heart valves ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Heart attack ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Heart murmur ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Low blood pressure ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>High blood pressure ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Other congenital heart defects ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>	<p style="text-align: right;"><b>Yes No DK</b></p> <p>Mitral valve prolapse ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Pacemaker ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Rheumatic fever ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Rheumatic heart disease ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Abnormal bleeding ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Anemia ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Blood transfusion ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p style="padding-left: 20px;">If yes, date: _____</p> <p>Hemophilia ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>AIDS or HIV infection ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Arthritis ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
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Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? .....

Name of physician or dentist making recommendation: \_\_\_\_\_ Phone: *Include area code* ( )

Do you have any disease, condition, or problem not listed above that you think I should know about? .....

Please explain: \_\_\_\_\_

**NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.**

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Dentist: \_\_\_\_\_ Date: \_\_\_\_\_

**FOR COMPLETION BY DENTIST**

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### HIPPA NOTICE OF PRIVACY PRACTICES

Federal protection for the privacy of health information and personal information is in effect. The HIPAA Notice of Privacy Practices for this dental office is available at the front desk when requested. Your signature below indicates that you are acknowledging notification of the privacy practices of this office.

Acknowledgement of Privacy Rules: \_\_\_\_\_ Date: \_\_\_\_\_

### ARBITRATION AGREEMENT

This dental practice agrees to provide to the undersigned patient dental health care services in consideration for the payment received. By signing this arbitration clause, you are agreeing to have any issue of dental malpractice decided by neutral arbitration and you are giving up your right to a jury or court trial. The arbitration agreement you are accepting is available at the front desk when requested.

- I have read the material available at the front desk.
- I would like to request a printed copy to take with me.

Acknowledgement of Arbitration Agreement: \_\_\_\_\_ Date: \_\_\_\_\_

### SOCIAL MEDIA AUTHORIZATION

At Optima, we strive to create a family environment for our patients. We regularly interact with our patients and community through social media. We need your written consent if you would like us to include your smile in our online platforms.

- You may use my first name & photo on your Web site gallery and social media pages. This may include Facebook, Google+, Twitter, Instagram, and Pinterest.
- You may use my photo as referenced above, but no name.
- I would prefer that my smile is not featured online.

Patient Authorization: \_\_\_\_\_ Date: \_\_\_\_\_

## FINANCIAL AGREEMENT

In an effort to maintain treatment fees at a minimum while maintaining a high level of professional care, we have established the following financial policy for our office. Please feel free to discuss our fees with us at any time. Before any dental treatment is begun, the patient and/or responsible party will receive a consultation regarding treatment plan and cost.

We require payment in full for the portion, not covered by dental insurance, of dental services to be rendered. For procedures that take multiple appointments to complete, payment may be split up over the number of appointments required. Any other financial arrangements shall be made only at the finance manager and/or doctor's discretion. We accept cash, checks, Amex Visa, MasterCard, Discover, and upon request, we can also provide information regarding financial companies to help assist with the cost of your dental procedures such as Care Credit, and Citi Health. Credit applications for such financing options are available upon request.

As a courtesy to our patients with insurance, we will file your insurance claim, allowing you to pay only your deductible and/or **estimated** co-payment as services are rendered. Please remember that the contract is between you and your insurance company and your **total balance in our office is always your responsibility. Please note that we allow 60 days for dental claim to be paid.** We make every effort to give you an accurate estimate of what your portion of our fees will be, based on the information provided to us. However, we have no way to guarantee the actual terms of your policy. If for any reason there is a balance remaining after your insurance company's payment, you will be sent statement. Any dispute regarding reimbursement or the amount of reimbursement is between you and your insurance carrier. **By agreeing to this policy you agree to all such conditions.**

We schedule our appointments to provide each patient with our undivided attention. In order to accomplish this, **please be advised that you will be charged for cancellations with less than 24 hours notice** at the rate of \$50.00 for examination/hygiene appointments and \$75.00 for dental procedures appointments. Also note that any type of deposits and/or payments towards the cosmetic cases will not be refunded. Should the patient change their mind for whatever reason during treatment, patient will be responsible for all costs incurred including **lab fees and related costs.**

An account with an unpaid balance past 60 days will be sent to a collection agency. At that time, you will be responsible for any and all costs incurred in the collection of your debt from the last date of service, such as attorney fees, court fees and any other fees associated with the collection of your debt.

Original records including radiographs are the property of this office. If you desire, we will provide you with a copy of your record or radiographs for a nominal duplication fee of \$25.

We appreciate your confidence in choosing our practice. Please do not hesitate to inquire with a staff member should you have any questions regarding this policy.

**I have read, understood, and agree to the Office Financial Policy stated above.**

Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_