

WELCOME TO OUR PRACTICE!



Please take a few minutes to answer the following questions
so we can better assist you with your health care needs

PATIENT INFORMATION

Date : _____ Soc. Sec. # : _____ Birth date : _____

Last Name : _____ First Name : _____ Initial : _____

Address : _____ Cell : _____ Home Phone: _____

City : _____ State : _____ Zip : _____

Sex : M F

Minor Single Married Long Term Partner Divorced Widowed Separated

Employer : _____ Business Phone : _____

Business Address : _____ Occupation : _____

Who should we thank for referring you? _____

In case of emergency, who should we contact? _____ Phone : _____

PRIMARY INSURANCE

Person Responsible for Account:

Last Name: _____ First Name: _____ Initial: _____

Relationship to Patient: _____ Birth date : _____ Soc. Sec # : _____

Address: _____ Cell: _____ Home Phone: _____

City: _____ State : _____ Zip : _____

Responsible Party Employed By: _____ Business Phone : _____

Business Address: _____ Occupation: _____

Insurance Company: _____

Insurance Company Address: _____

Subscriber I.D.#: _____ Group #: _____

ADDITIONAL INSURANCE

Insured Name:

Last Name : _____ First Name : _____ Initial : _____

Relationship to Patient : _____ Birth date : _____ Soc. Sec # : _____

Address: _____ Home Phone: _____

City: _____ State: _____ Zip : _____

Insured Employed By : _____ Business Phone : _____

Insurance Company : _____

Insurance Company Address : _____

Subscriber I.D.#: _____ Group #: _____

HEALTH HISTORY

Correct answers to the following questions will allow your dentist to treat you on a more individual basis, providing the care appropriate for your particular needs.

Name: _____ Birth date : _____ Age : _____

Why are you now seeking dental treatment? _____

Please answer each question. Check YES or NO. If in doubt, leave blank

- | | Yes | No |
|--|--------------------------|--------------------------|
| 1. Are you in good health now? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are you now under the care of physician? | <input type="checkbox"/> | <input type="checkbox"/> |
| If so, what is the condition being treated? _____ | | |
| 3. Have you ever been hospitalized or had a serious illness? | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, explain _____ | | |
| 4. Have you ever had excessive bleeding following an extraction, or do cuts take longer to heal now than previously? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. (Woman) Are you pregnant? If so, give due date _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you use tobacco in any form? If yes, how much _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do you use alcoholic beverages (more than 2 drinks per day) ? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Do you have or have you ever had any of the following? | | |

GENERAL

- | | YES | NO |
|-----------------------------|--------------------------|--------------------------|
| Tire easily, weakness | <input type="checkbox"/> | <input type="checkbox"/> |
| Marked weight change | <input type="checkbox"/> | <input type="checkbox"/> |
| Night sweats | <input type="checkbox"/> | <input type="checkbox"/> |
| Persistent fever | <input type="checkbox"/> | <input type="checkbox"/> |

SKIN

- | | | |
|-------------------------------|--------------------------|--------------------------|
| Eruptions (rash) hives | <input type="checkbox"/> | <input type="checkbox"/> |
| Change color skin color | <input type="checkbox"/> | <input type="checkbox"/> |

EYES

- | | | |
|---------------------|--------------------------|--------------------------|
| Visual change | <input type="checkbox"/> | <input type="checkbox"/> |
| Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> |

EARS

- | | | |
|-----------------------|--------------------------|--------------------------|
| Loss of hearing | <input type="checkbox"/> | <input type="checkbox"/> |
| Ringing in ears | <input type="checkbox"/> | <input type="checkbox"/> |

NOSE

- | | | |
|---------------------------|--------------------------|--------------------------|
| Frequent nosebleeds | <input type="checkbox"/> | <input type="checkbox"/> |
| Sinus problems | <input type="checkbox"/> | <input type="checkbox"/> |

THROAT

- | | | |
|---------------------------|--------------------------|--------------------------|
| Soreness/hoarseness | <input type="checkbox"/> | <input type="checkbox"/> |
|---------------------------|--------------------------|--------------------------|

NERVOUS SYSTEM

- | | | |
|------------------------------|--------------------------|--------------------------|
| Stroke | <input type="checkbox"/> | <input type="checkbox"/> |
| Headaches | <input type="checkbox"/> | <input type="checkbox"/> |
| Convulsions / epilepsy | <input type="checkbox"/> | <input type="checkbox"/> |
| Numbness / tingling | <input type="checkbox"/> | <input type="checkbox"/> |
| Dizziness / fainting | <input type="checkbox"/> | <input type="checkbox"/> |
| Psychiatric treatment | <input type="checkbox"/> | <input type="checkbox"/> |

RESPIRATORY

- | | | |
|---|--------------------------|--------------------------|
| Tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> |
| Emphysema | <input type="checkbox"/> | <input type="checkbox"/> |
| Asthma / hay fever | <input type="checkbox"/> | <input type="checkbox"/> |
| Persistent cough | <input type="checkbox"/> | <input type="checkbox"/> |
| Sputum production (phlegm) | <input type="checkbox"/> | <input type="checkbox"/> |
| Cough up bloody sputum | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty breathing while lying down | <input type="checkbox"/> | <input type="checkbox"/> |

ENDOCRINE

- | | | |
|----------------------------------|--------------------------|--------------------------|
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> |
| Family history of diabetes | <input type="checkbox"/> | <input type="checkbox"/> |
| Thyroid condition/goiter | <input type="checkbox"/> | <input type="checkbox"/> |
| Other | <input type="checkbox"/> | <input type="checkbox"/> |

HEART/BLOOD VESSELS

- | | YES | NO |
|--------------------------------|--------------------------|--------------------------|
| Rheumatic fever | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart murmur | <input type="checkbox"/> | <input type="checkbox"/> |
| Chest pain/discomfort | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart attack/trouble | <input type="checkbox"/> | <input type="checkbox"/> |
| Shortness of breath | <input type="checkbox"/> | <input type="checkbox"/> |
| Swelling of ankles | <input type="checkbox"/> | <input type="checkbox"/> |
| High Blood pressure | <input type="checkbox"/> | <input type="checkbox"/> |
| Congenital heart disease | <input type="checkbox"/> | <input type="checkbox"/> |
| Mitral valve prolapsed | <input type="checkbox"/> | <input type="checkbox"/> |
| Artificial heart valve | <input type="checkbox"/> | <input type="checkbox"/> |
| Pacemaker | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart surgery | <input type="checkbox"/> | <input type="checkbox"/> |
| Other | <input type="checkbox"/> | <input type="checkbox"/> |

BONE/MUSCLES

- | | | |
|-------------------------------|--------------------------|--------------------------|
| Arthritis/rheumatism | <input type="checkbox"/> | <input type="checkbox"/> |
| Artificial joints/limbs | <input type="checkbox"/> | <input type="checkbox"/> |

DIGESTIVE SYSTEM

- | | | |
|------------------------------------|--------------------------|--------------------------|
| Hepatitis | <input type="checkbox"/> | <input type="checkbox"/> |
| Jaundice | <input type="checkbox"/> | <input type="checkbox"/> |
| Ulcers | <input type="checkbox"/> | <input type="checkbox"/> |
| Change in appetite | <input type="checkbox"/> | <input type="checkbox"/> |
| Black, bloody or pale stools | <input type="checkbox"/> | <input type="checkbox"/> |

UNIRARY

- | | | |
|--|--------------------------|--------------------------|
| Kidney disease | <input type="checkbox"/> | <input type="checkbox"/> |
| Increase in frequency of urination (night) | <input type="checkbox"/> | <input type="checkbox"/> |
| Burning on urination | <input type="checkbox"/> | <input type="checkbox"/> |
| Urethral discharge | <input type="checkbox"/> | <input type="checkbox"/> |
| Bloody urine | <input type="checkbox"/> | <input type="checkbox"/> |
| Venereal disease | <input type="checkbox"/> | <input type="checkbox"/> |

BLOOD

- | | | |
|-------------------------|--------------------------|--------------------------|
| Bruise easily | <input type="checkbox"/> | <input type="checkbox"/> |
| Anemia | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood transfusion | <input type="checkbox"/> | <input type="checkbox"/> |

OTHER

- | | | |
|-------------------------|--------------------------|--------------------------|
| Radiation therapy | <input type="checkbox"/> | <input type="checkbox"/> |
| Chemotherapy | <input type="checkbox"/> | <input type="checkbox"/> |
| Tumors or growths | <input type="checkbox"/> | <input type="checkbox"/> |
| Cancer | <input type="checkbox"/> | <input type="checkbox"/> |
| HIV+ | <input type="checkbox"/> | <input type="checkbox"/> |
| AIDS | <input type="checkbox"/> | <input type="checkbox"/> |

Please complete reverse side

9. Are you ALLERGIC or have you experienced any reaction to the following?

	YES	NO		YES	NO
Local anesthetics (e.g. novocaine).....	<input type="checkbox"/>	<input type="checkbox"/>	Aspirin or codeine	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates/sedatives/sleeping pills	<input type="checkbox"/>	<input type="checkbox"/>	Sulfa drugs	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin/other antibiotics	<input type="checkbox"/>	<input type="checkbox"/>	Other allergies _____		

10. Are you taking any of the following?

	YES	NO		YES	NO
Antibiotics/sulfa drugs	<input type="checkbox"/>	<input type="checkbox"/>	Tranquilizers	<input type="checkbox"/>	<input type="checkbox"/>
Blood thinners	<input type="checkbox"/>	<input type="checkbox"/>	Insulin/other diabetes drugs	<input type="checkbox"/>	<input type="checkbox"/>
Blood pressure medication	<input type="checkbox"/>	<input type="checkbox"/>	Recreational drugs	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid medicine	<input type="checkbox"/>	<input type="checkbox"/>	Digitalis/others heart medications	<input type="checkbox"/>	<input type="checkbox"/>
Cortisone/steroids	<input type="checkbox"/>	<input type="checkbox"/>	Nitroglycerin	<input type="checkbox"/>	<input type="checkbox"/>
Antihistamines/allergy drugs/cold remedies	<input type="checkbox"/>	<input type="checkbox"/>	Aspirin	<input type="checkbox"/>	<input type="checkbox"/>
			Other medication _____		

If yes to any of the above, list **name** of medication and **dosage** below:

1. _____
2. _____
3. _____
4. _____

11. Is there any disease, condition or problem not listed that you think we should know about, or is there any activity your doctor says you cannot do? If so, explain _____

12. Physician's Name _____ Phone _____

13. Have you ever had any serious trouble associated with previous dental treatment? _____

14. Does dental treatment make you nervous? No _____ Slightly _____ Moderately _____ Extremely _____

15. Date of last dental visit _____

16. Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? _____
If so, when? _____

17. Do you have or have you ever had any of the following?

MOUTH

	YES	NO
Bleeding, sore gums	<input type="checkbox"/>	<input type="checkbox"/>
Unpleasant taste/bad breath	<input type="checkbox"/>	<input type="checkbox"/>
Burning tongue/lips	<input type="checkbox"/>	<input type="checkbox"/>
Frequent blisters, lips/mouth	<input type="checkbox"/>	<input type="checkbox"/>
Swelling/lumps in mouth	<input type="checkbox"/>	<input type="checkbox"/>
Ortho treatment (braces)	<input type="checkbox"/>	<input type="checkbox"/>
Biting cheeks/lips	<input type="checkbox"/>	<input type="checkbox"/>
Clicking/popping jaws	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty opening or closing jaw	<input type="checkbox"/>	<input type="checkbox"/>

TEETH

	YES	NO
Loose teeth	<input type="checkbox"/>	<input type="checkbox"/>
Sensitive to hot	<input type="checkbox"/>	<input type="checkbox"/>
Sensitive to cold	<input type="checkbox"/>	<input type="checkbox"/>
Sensitive to sweets	<input type="checkbox"/>	<input type="checkbox"/>
Sensitive to biting	<input type="checkbox"/>	<input type="checkbox"/>
Food impaction	<input type="checkbox"/>	<input type="checkbox"/>
Clenching/grinding	<input type="checkbox"/>	<input type="checkbox"/>
Shifting of teeth	<input type="checkbox"/>	<input type="checkbox"/>
Change in bite	<input type="checkbox"/>	<input type="checkbox"/>

ORAL HYGIENE

Do you use the following?

	YES	NO
Brush	<input type="checkbox"/>	<input type="checkbox"/>
Dental floss	<input type="checkbox"/>	<input type="checkbox"/>
Fluoride rinse	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		

How often do you brush _____

Brush is: Soft Medium Hard

To the best of my knowledge, all of the preceding answers are true and correct.

If I ever any change in my health or change in my medication, I will inform the dentist at the next appointment.

Signature of Patient _____

Parent or Guardian _____ Date _____

FINANCIAL POLICY

This statement is to inform you of our financial policy. We are committed to providing you with the highest quality dental care using only the best materials and technology available. We are also committed to providing you with up-to-date information and educational tool so that we may assist you in maintaining optimum oral health. Our financial policy is intended to facilitate excellent service to you while minimizing our administrative costs.

Payment is expected at the time of service. If you have dental insurance your estimated co-pay is also expected. We accept cash, personal checks and all major credit cards. Outside financing is available through Care Credit and Capital One upon request and approval.

If your account is turned over to our **collection agency** then **you** will be responsible for all **collection costs**. Additionally, our office charges for **broken** and **cancelled** appointments without 48 hour advanced notice.

Print Name

Signature

Date

ASSIGNMENT OF BENEFITS

All charges you incur are **your responsibility** regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with **you**, our patient, not your insurance company. If your dental insurance denies a claim, the balance is **your responsibility**. As a courtesy to you we will help you process all insurance claims. You may direct your insurance company to pay your benefits directly to our office by signing the authorization below.

I have read and understand the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to Waterford Dental Assoc.

Print Name

Signature of Patient or
Responsible Party

Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have been made aware that there is a copy of the office's Notice of Privacy Practices for my review.

____initial