Glendora DENTAL ARTS

PATIENT INFORMATION

We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you.

PERSONAL

Name_____
Last First MI (Preferred)

Birthdate_____ SS#_____ Gender: [ ] M [ ] F Married: [ ] Y [ ] N

Home Phone_____Work Phone_____ Cell Phone_____

Email_____

Preferred contact method [ ] HmPhone [ ] WkPhone [ ] Cell Phone [ ] Email

Student status if dependent over 19 (for ins) [ ] Nonstudent [ ] Fulltime [ ] Parttime

How did you hear about us?

_____

(If someone referred you here, please write down their name so we can thank them.)

ADDRESS AND HOME PHONE

Check box if same for entire family [ ]

Address_____

Address 2_____

City_____ State_____Zip_____

Home Phone_____

PRIMARY INSURANCE

Your relationship to subscriber: [ ] Self [ ] Spouse [ ] Child

Subscriber Name_____Subscriber ID # _____

Insurance Company _____Phone_____

Employer_____Group Name_____Group #_____

Please present insurance card to receptionist.

SECONDARY INSURANCE

Your relationship to subscriber: [ ] Self [ ] Spouse [ ] Child

Subscriber Name_____Subscriber ID # _____

Insurance Company _____Phone_____

Employer_____Group Name_____Group #_____

Comments:

F0INANCIAL AGREEMENT

* For my convenience, this office may release my information to my insurance company, and receive payment directly from them.
* I understand that if I begin major treatment that involves lab work, I will be responsible for the fee at that time.
* I agree to let this office run a credit report. [ ] Yes [ ] No If no, then all fees are due at time of service.
* If sent to collections, I agree to pay all related fees and court costs.
* Every effort will be made to help me with my insurance, but if they do not pay as expected, I will still be responsible.
* I agree to pay finance charges of 1.5% per month (18% APR) on any balance 90 days past due.
* I will pay a fee for appointments broken without 24 hours notice.
* Treatment plans may change, and I will be responsible for the work actually done.

Signature_____ Date_____

NOTICE OF PRIVACY POLICIES

I have had full opportunity to read and consider the contents of the Notice of Privacy Practices. I understand that I am giving my permission to your use and disclosure of my protected health information in order to carry out treatment, payment activities and healthcare operations. I also understand that I have the right to revoke permission.

Signature_____ Date_____

MEDICAL HISTORY

Name of Medical Doctor:_____ City/State_____

Emergency Contact_____ Phone_____Relationship_____

List all the medications or drugs you are now taking:

[ ] None_____

_____

_____

_____

_____

List all the medications or drugs you are allergic to:

[ ] None_____

_____

_____

_____

_____

List any medical conditions you may have including: asthma, bleeding problems, cancer, diabetes, heart murmur, heart trouble, high blood pressure, joint replacement, kidney disease, liver disease, pregnancy, psychiatric treatment, sinus trouble, stroke, ulcers, or history of rheumatic fever or of taking fen-phen.

[ ] None_____

_____

_____

_____

Tobacco use? If so, what kind and how much?_____

Unusual reaction to dental injections?_____

Reason for today's visit_____ Are you in pain? _____

New patients:

Do you have a Panoramic x-ray or Full Mouth x-rays that are less than 5 years old? _____

Do you have BiteWing x-rays that are less than 1 year old?_____

Name of former dentist_____ City/State_____

Date of last cleaning and exam_____

Signature_____Date_____

If you need more space, you may continue below:

Health History

Chart No._____

Patient Name:_____ Date:_____

Date of Birth:_____ Sex: M / F Height:_____ Weight:_____

Answer all questions and fill in blank spaces when indicated. Answers to the following questions are for our records only and will be strictly confidential.

		Yes	No
1.	Are you in good health?		
2.	Has there been any change in your general health within the past year? My last physical was on _____		
3.	The name and telephone #of my physician is: _____ _____		
4.	Are you now under the care of a physician? If so, what is the condition being treated _____ _____ _____		
5.	Please list all current medications _____ _____ _____		
6.	Have you ever been hospitalized from or have had a serious illness or operation in the last 5 years? If so, please explain _____ _____ _____		
7.	Do you have, or have you had, any of the following diseases or problems?: A. Damaged heart valves or artificial heart valves, congenital heart lesions or Mitral Valve Prolapse?		
	B. Cardiovascular disease, heart trouble, heart attack, coronary insufficiency, coronary occlusion, arteriosclerosis, or stroke?		
	C. High/low blood pressure?		
	• Do you have pain in chest upon exertion?		
	• Are you ever short of breath after mild exercise?		
	• Do your ankles swell?		
	• Do you get short of breath when you lie down, or do you require extra pillows when you sleep?		
	D. A cardiac pacemaker?		
	E. Rheumatic Fever/Heart Disease?		

Health History

		Yes	No
	F. Asthma; respiratory disease, COPD, or Sinus trouble?		
	G. Hives or skin rash?		
	H. Fainting spells or seizures?		
	I. Diabetes • Do you have to urinate (pass water) more than 6 times a day?		
	• Are you thirsty much of the time?		
	• Does your mouth frequently become dry?		
	J. Hepatitis, jaundice or liver disease?		
	K Arthritis, Inflammatory rheumatism (swollen joints)?		
	L. Stomach ulcers		
	M. Kidney trouble?		
	N. Tuberculosis?		
	O. Do you have a persistent cough or cough up blood?		
	P Do you have any prosthetic hip or joint prosthesis, implants, bone plates or pins? If so, what _____		
	Q. Do you or have you taken Bisphophonates (ie: Fosamax, Boniva, Evista, Actonel, Alendronate, etc)? If yes, when? _____ Prescribing Doctor's Name and telephone: _____ _____		
8.	Have you had abnormal bleeding associated with previous dental extractions, surgery, or trauma?		
	• Do you bruise easily?		
	• Have you ever required a blood transfusion? if so, explain _____		
9.	Do You have any blood disorder such as anemia?		
10.	Do you drink Alcoholic Beverages ?		
11.	Do you Smoke? If so, how much _____		
12.	Have you had surgery or x-ray treatment for a tumor, growth, or other condition of your mouth or lips?		

Health History

		Yes	No
13.	Are you taking any of the following: A. Antibiotics or sulfa drugs?		
	B. Anticoagulants (blood thinners)? If so, what _____		
	C. Medicine for high blood pressure?		
	D. Cortisone (steroids)?		
	E. Tranquilizers?		
	F. Antihistamine?		
	G. Insulin, tolbutamide (orinase) or similar drug?		
	H. Digitalis or drugs for heart trouble?		
	I. Nitroglycerin?		
	J. Oral contraceptive or other hormonal therapy?		
	K. Other?		
14.	Are you allergic or have you reacted adversely to any of the following? A. Local anesthetics?		
	B. Penicillin or other antibiotics?		
	C. Sulfa drugs?		
	D. Barbiturates, sedatives or sleeping pills?		
	E. Aspirin?		
	F. Iodine?		
	G. Codeine or other narcotics?		
	H. Are you allergic to latex or rubber products?		
	I. Other?		
15.	Have you had any problems or serious trouble associated with any previous dental treatment? If so, please explain _____ _____		
16.	Do you have any disease, condition, or problem not listed above that you think we should know about? If so, please explain _____ _____		

Health History

		Yes	No
17.	Are you employed in any situation which exposes you regularly to x-rays or other ionizing radiation?		
18.	Do you have, or have you been in contact with anyone who has the following? A. Herpes?		
	B. Hepatitis?		
	C. TB?		
	D. AIDS?		
	E. Venereal Disease?		
	F. HIV?		
19.	Are you pregnant or think you might be?		
20.	Are you nursing?		

I have filled out this Health Questionnaire completely. I have advised you of all medical problems of which I am aware. I further certify that I, the undersigned, consent to the performing of x-rays, examination and whatever dental treatment may be agreed upon to be necessary or advisable.

Signature:_____ Date: ___/___/___
(Patient or Legal Representative)

Signaure of Doctor:_____ Name of Doctor (print)_____ Date:___/___/___

UPDATE TO MEDICAL HISTORY

Date	Comments	Patient Signature	Doctor Signature