Health History Form

ADA American Dental Association®

America's leading advocate for oral health

Persistent cough greater than a 3 week duration	Email: Today's Dat	te:					est voi oval medicin
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Have you had any problems associated with previous dental treatment?	Have you ever had orthodontic (braces) treatment?		Do you wear dentures	or partiale?	100(117		
Syour home water supply fluoridated?	Have you had any problems associated with previous dental treatment?		Do you participate in	active recreation	nal activition?	······································	
Do you drink bottled or filtered water?	Is your home water supply fluoridated?		Have you ever had a s	erious injury to	vous bood		
What was done at that time? Are you currently experiencing dental pain or discomfort?	Do you drink bottled or filtered water?		Date of your last dent	al ovam:	your nead or mouth	· · · · · · · · · · · · · · · · · · ·	
Are you now under the care of a physician? Phone: Include area code () Address/City/State/Zip: Are you in good health? Are you general health within the past year? Are you general health within the past year? Pate of last physical exam: Date of last dental x-rays: Date of last de	If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY						
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Are you in good health? Are you general health within the past year? Date of last physical exam: Yes No DK Yes No DK Have you had a serious illness, operation or been hospitalized in the past 5 years? If yes, what was the illness or problem? Are you taking or have you recently taken any prescription or over the counter medicine(s)? If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements: Date of last physical exam:							
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Physician Name: Phone: Include area code () Address/City/State/Zip: Are you in good health? Has there been any change in your general health within the past year? Page, what condition is being treated? Page 2012 American Dental Association	VAS NA	lo DK					Yes No DK
Address/City/State/Zip: Are you taking or have you recently taken any prescription or over the counter medicine(s)? Has there been any change in your general health within the past year? Page, what condition is being treated? Date of last physical exam:			Have you had a serious	illness, operati	on or been hospitaliz	zed	
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Medical Information Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems. (Check DK if you Don't Know the answer to the question) Yes No DK Yes No DK Do you use controlled substances (drugs)?..... Do you wear contact lenses?.... Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? □ □ Do you use tobacco (smoking, snuff, chew, bidis)?..... If so, how interested are you in stopping? Circle one: VERY / SOMEWHAT / NOT INTERESTED Date: _____ If yes, have you had any complications? ____ Do you drink alcoholic beverages?..... Are you taking or scheduled to begin taking an antiresorptive agent If yes, how much alcohol did you drink in the last 24 hours? (like Fosamax®, Actonel®, Atelvia, Boniva®, Reclast, Prolia) for osteoporosis or Paget's disease? If yes, how much do you typically drink i n a week? _____ Since 2001, were you treated or are you presently scheduled to begin WOMEN ONLY Are you: treatment with an antiresorptive agent (like Aredia®, Zometa®, XGEVA) Pregnant?.. for bone pain, hypercalcemia or skeletal complications resulting from Number of weeks: Paget's disease, multiple myeloma or metastatic cancer?..... Taking birth control pills or hormonal replacement? Date Treatment began: __ Nursing? Allergies. Are you allergic to or have you had a reaction to: To all **yes** responses, specify type of reaction. Yes No DK Metals __ _ _ _ _ Local anesthetics ____ Latex (rubber) Aspirin Penicillin or other antibiotics Hay fever/seasonal _____ Barbiturates, sedatives, or sleeping pills _____ Animals _____ Sulfa drugs _ Food _____ Codeine or other narcotics ____ Other _____ Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems. Yes No DK Yes No DK Yes No DK Artificial (prosthetic) heart valve..... Autoimmune disease..... Glaucoma Previous infective endocarditis..... Rheumatoid arthritis..... Hepatitis, jaundice or Damaged valves in transplanted heart liver disease..... Systemic lupus erythematosus...... Congenital heart disease (CHD) Epilepsy Asthma..... Fainting spells or seizures Unrepaired, cyanotic CHD..... Bronchitis Neurological disorders Repaired (completely) in last 6 months..... If yes, specify:_____ Repaired CHD with residual defects Emphysema..... Sleep disorder Sinus trouble Except for the conditions listed above, antibiotic prophylaxis is no longer recommended Do you snore?.... Tuberculosis..... for any other form of CHD. Mental health disorders...... Cancer/Chemotherapy/ Specify: Radiation Treatment..... Yes No DK Yes No DK Recurrent Infections Chest pain upon exertion...... □ □ □ Cardiovascular disease Mitral valve prolapse..... Type of infection: Angina..... Chronic pain Pacemaker..... Kidney problems..... Arteriosclerosis..... Diabetes Type I or II Rheumatic fever..... Night sweats Congestive heart failure...... Eating disorder Rheumatic heart disease...... Osteoporosis..... Damaged heart valves Abnormal bleeding..... Malnutrition Persistent swollen glands Heart attack Gastrointestinal disease...... Anemia in neck..... Severe headaches/ Heart murmur..... Blood transfusion..... G.E. Reflux/persistent migraines..... If yes, date:_____ Low blood pressure heartburn Severe or rapid weight loss Ulcers Hemophilia High blood pressure..... Sexually transmitted disease .. \square \square AIDS or HIV infection...... Other congenital Thyroid problems Excessive urination heart defects..... Arthritis..... Stroke..... 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:



Employee signature:

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES and CONSENT FORM

Date:

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. These rights are more fully described in our Notice of Privacy Practices, updated effective February 17, 2015. We are permitted to review our Notice of Privacy Practices at any time. We will provide you with a copy of the revised Notice of Privacy Practices upon your request.

Nuthorization of PHI Disclosure - I,	give, Schreder Family Dental,
	hine/cell phone or with other family members in my household of
	ments or to let me know of any treatments that I may require when
	nily Dental to release information required to insurance
companies/third party billings to secure the paymen	•
also authorize the following person(s) to have acce	ess to the information covered under the Privacy Act regarding myself
or my children:	
Name and Relationship:	
Name and Relationship:	
Family members who are in my household where-	as this HIPAA form will also cover:
	DOB:
Name:	DOB:
Name:	DOB:
Name:	DOB:
insurance contestability period or with respect to d accordance with this authorization. I understand the this authorization, the information may no longer be re-disclosure by the recipient of the information. By signing below, I am acknowledging that I have receivalso giving Schreder Family Dental consent to disclose the second	understand that I may not revoke this authorization during an lisclosures that Schreder Family Dental may have already made in lat when Schreder Family Dental discloses information pursuant to be protected by federal or state privacy rules and may be subject to lived a copy of Schreder Family Dental's Notice of Privacy Practices. I among protected health information to the person(s) listed above until such consent Form is completed by me. I also understand and agree to the terms
Patient Name:	DOB:
Signature:	Date:
If signed by Patient Representative, relationship t	o patient:
To be completed by Schreder Family Dental personnel if form	is not signed:
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unable to do so.	tain the patient's acknowledgment of receipt of Notice of Privacy Practices, but was
Reason acknowledgement and consent was not obtained:	

CONSENT FOR TREATMENT & OFFICE POLICIES

PAYMENT FOR SERVICES

As a condition of your treatment by this office, financial arrangements must be made in advance. All co-payments are due at the time services are rendered.

In the event that your account is turned over to a collection agency for non-payment you will be responsible for any collection fees and/or court costs.

Any emergency and/or after hours dental services are subject to additional fees.

DENTAL INSURANCE POLICY

Patients who carry dental insurance understand that payment for services is ultimately their responsibility. This office cannot render services on the assumption that our charges will be paid by an insurance company. As a courtesy to our patients, we will prepare and submit dental claims and assist in making collections from insurance companies. Any such collections will be credited to the patient's account.

Knowing your insurance coverage is your responsibility. Insurance estimates are not a guarantee of coverage.

DOWNGRADED SERVICES

In this office we believe in providing our patients with the utmost in care. This means using the best materials available in order to promote and preserve a healthy smile. We understand that your dental insurance may downgrade procedures and the patient is responsible for any difference in cost.

X-RAYS AND PHOTOGRAPHS

I authorize Dr. Kara and her team to take any x-rays and photographs deemed necessary for the detection and diagnosis of oral diseases. I authorize the release of this and any other information to my insurance company necessary for processing my dental claim (if applicable and according to HIPPA regulations).

APPOINTMENT POLICY

If you find it impossible to keep an appointment, for consideration of other patient's needs, we ask for 48 hours' notice. Appointments cancelled or missed without 48 hours' notice are subject to a missed appointment fee.

Failure to give 24-hours' notice to reschedule a Saturday or an evening appointment will result in being unable to schedule future appointments at those times.

By signing below you ar	e acknowledging you have read and understand our office policies.
Signature of Patient or	Responsible Party
Date:	Relationship to Patient: