Medical History

Patient Name: ________________________________Guardian Name (if minor): ________________________

Date of Birth: ______________________ M_____ F_______

Address: ____

City____Postal Code______________

Email: ____________________________ Home Phone: _________________ **Cell Phone:** _______________

Best way to contact you: □ Cell □Home □Phone □Text □Email Occupation: ____________________________

Physician Name: _________________________ Phone Number: ___________________________

Specialists Name: ________________________ Phone Number: ___________________________

Insurance Information

Primary Coverage

Name of Insured__________________________ Birthdate_______________________________

Place of Employment______________________ **Insurance Company**_________________________

Group/Policy #___________________________ Certificate/ID____________________________

Basic_____ Major_____ Financial Limit__________

Secondary Insurance

Name of Insured__________________________ Birthdate_______________________________

Place of Employment______________________ **Insurance Company**_________________________

Group/Policy #___________________________ Certificate/ID____________________________

Basic_____ Major_____ Financial Limit__________

Who should we thank for referring you: ___________________________________

What is your estimate general health? □**Excellent** □**Good** □**Fair** □**Poor**

DO YOU HAVE or HAVE YOU EVER HAD

1. Hospitalization for illness or injury: □**Yes** □**No** If **yes** please provide details: ___________________________

2. An Allergic reaction to (please check): □aspirin □ibuprofen □acetaminophen □codeine □penicillin □tetracycline □local anesthetic □metals (nickel, gold, silver) □fluoride □sulfa □erythromycin □latex □other_________________________________

3. Do you have a history of any of the following that may require antibiotic coverage?
   - Artificial heart valves. □**Yes** □**No**
   - A history of infective endocarditis. □**Yes** □**No** □ A heart conditions present from birth including:
     a. Unrepaired or incompletely repaired cyanotic congenital heart disease, including those with palliative shunts and conduits. □**Yes** □**No**
     b. A completely repaired congenital heart defect with prosthetic material or device, whether placed by surgery or by catheter intervention with in the last six months. □**Yes** □**No**

c. Any repaired congenital heart defect with residual defect at the site or adjacent to the site of a prosthetic patch or a prosthetic device. □**Yes** □**No**

d. Cardiac transplant that developed a problem in a heart valve. □**Yes** □**No**

4. Joint Replacement: □**Yes** □**No** If **yes** what joint? ________________________ When? ________________

5.

	Yes	No		Yes	No
Heart Attack - Date:			**Emotional Disorders**		
Cardiac Stent(s) - Date:			**Psychiatric Treatment**		
Stroke - Date:			**Depression**		
High or Low Blood Pressure			**Neurologic problems (ADD)**		
Muscular dystrophy, multiple sclerosis			**Epilepsy, convulsion (seizures)**		
Anemia or other blood disorder			**Hepatitis - Type:**		
Prolonged bleeding due to slight cut			**Breathing or Sleep Problems (i.e. snoring, sinus)**		
On blood thinners i.e. Coumadin, Adult Aspirin, Plavix (INR #: ________)			**Unexplained sore throat, feeling like something is caught in throat or chronic hoarseness.**		
Emphysema			**HIV/AIDS**		
Tuberculosis			**Colitis/Cohn's**		
Asthma: If yes where do you keep your inhaler?			**Eating Disorder (Bulimia, Anorexia Nervosa)**		
Thyroid Disease			**Taking meds for weight management (i.e. fen-phen)**		
Kidney Disease			**Cold Sores**		
Liver Disease			**Head or Neck injuries**		
Jaundice			**Lumps or swelling in the mouth or neck area**		
Cancer - Type:			**Digestive disorders (i.e. Gastric reflux)**		
Radiation/Chemotherapy			**Drug Dependency - Type:**		
Male Only: Prostate disorders			**Consumer of alcohol - # times per week:**		

6. Female: □ Osteoporosis? If **No** have you ever been tested for osteoporosis? □Yes □No □ Take Fosamax, Fosamax plus D for osteoporosis or for any other reason? □ Prone to yeast infections

7. Any medical condition(s) or impending surgery not listed □**Yes** □**No.** If yes please indicate:

____

List all prescribed medications & over-the-counter supplements and vitamins that you are currently taking.

Drug	Purpose	Drug	Purpose
______________________	______________________	______________________	______________________
______________________	______________________	______________________	______________________
______________________	______________________	______________________	______________________
______________________	______________________	______________________	______________________

Gum disease has been linked with an increased risk for many chronic diseases. Eliminating gum disease is especially important to the oral *and* overall health of the following patients (please indicate which apply):

□ **Tobacco User:**

□ **Yes** □ **No**

□ **Diabetes:**

What type? □ Type I □ Type II. Date of last HbA1c: ________________________.

Women:

□ Pregnant If **YES / No** how many weeks? ________ □ Nursing **YES / NO**

Dental History

Personal History		Yes	No
1.	Have you ever had an unfavorable or a complication(s) from past dental experience?		
2.	Have you ever had trouble getting numb or experienced a reaction to local anesthetic?		
3.	Do you have problems with your jaw joint/TMJ? (pain, sounds, limited opening, locking, popping)		
4.	Have you had orthodontic treatment? If yes when?		
5	Do you clench or grind during the day or been told you do so at night?		
6	Have you had gum surgery? If yes where and when?		
7.	Have you ever had your teeth cleaned with freezing?		

Our Office Policy

Dental Insurance

We are pleased to provide you the service of accepting payment directly from you insurance company, however, it is your responsibility to:

1. Know what your policy covers, deductibles, limits, etc.
2. If your insurance forms need to be filled out and signed by an employer, you must bring it with you, fully completed, before your appointment.
3. Pay your portion of the fees when required at each appointment.
4. Any fees not covered by your insurance policy will be your responsibility. (N.C. most insurance carriers do not pay 100% of the treatment cost for a variety of reasons.)
5. We will allow 6 (six) weeks from your appointment to receive payment from your insurance company. If payment is not received after 6 (six) weeks, you will be billed for the full amount.

Payment:

It is your responsibility to:

1. Pay your portion of the fee when required at the end of each appointment.
2. For extensive procedures involving lab work (e.g. crowns, dentures, implants), we will accept half (50%) of the fee on the initial appointment and the other (50%) when treatment is completed. Under no circumstance will we insert (dentures, crowns) unless Payment has been made in full.
3. Be aware that we charge 2% interest per month (i.e. 24% / year) on any outstanding balances.

Appointments

1. Once you book an appointment, we have set this time aside for you. It is your responsibility to be present for the appointment.
2. There will be a charge for any appointment missed or cancelled with less than 48 hours' notice.

Date: ____________________________ Patient Signature: ____