PAGES ARE DOUBLE SIDED



MEDICAL HISTORY

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate: \_\_\_/\_\_\_/\_\_\_\_\_\_\_

Are you under a physician’s care now? ( ) yes ( ) no

Physician’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physician’s Phone #: ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been hospitalized or had a major operation? ( ) yes ( ) no When: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you taking any medications, pills, or drugs? If yes, please provide a MED LIST:

­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­

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Do you take, or have you taken Phen-Fen or Redux? ( ) yes ( ) no

Have you ever taken Fosamax, Boniva, Actonel, or any other medication containing bisphosphonates? ( ) yes ( ) no

Are you on a special diet? ( ) yes ( ) no Do you use tobacco? ( ) yes ( ) no

Do you use controlled substances? ( ) yes ( ) no Which one(s)?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Women, are you: (circle all that apply) Pregnant Nursing Trying to get pregnant

Are you allergic to any of the following? (circle all that apply)

Aspirin Penicillin Codeine Local Anesthetics Acrylic Sulfa Drugs

Metal Latex Other(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have, or have you had, any of the following?

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Yes  | No |  | Yes  | No |  | Yes  | No |  | Yes  | No |
| Anemia  |  |  | Drug Addiction |  |  | Herpes  |  |  | Rheumatism  |  |  |
| Anaphylaxis |  |  | Easily Winded  |  |  | Shingles  |  |  | Scarlet Fever  |  |  |
| Alzheimer’s Disease  |  |  | Excessive Bleeding  |  |  | High Cholesterol  |  |  | High Blood Pressure  |  |  |
| AIDS/HIV Positive  |  |  | Epilepsy or Seizures  |  |  | Angina/ Chest Pains  |  |  | Sickle Cell Disease  |  |  |
| Hives or Rash  |  |  | Emphysema  |  |  | Hypoglycemia  |  |  | Sinus Trouble  |  |  |
| Arthritis/Gout  |  |  | Excessive Thirst |  |  | Stroke  |  |  | Spina Bifida  |  |  |
| Artificial Heart Valve  |  |  | Fainting Spells/Dizziness  |  |  | Kidney Problems |  |  | Stomach/Intestinal Disease  |  |  |
| Artificial Joint  |  |  | Frequent Cough  |  |  | Leukemia  |  |  | Irregular Heartbeat |  |  |
| Blood Transfusion  |  |  | Frequent Diarrhea  |  |  | Liver Disease  |  |  | Swelling of Limbs  |  |  |
| Blood Disease  |  |  | Genital Herpes  |  |  | Tuberculosis  |  |  | Thyroid Disease  |  |  |
| Asthma  |  |  | Glaucoma  |  |  | Lung Disease  |  |  | Tonsillitis  |  |  |
| Breathing Problem  |  |  | Hay Fever  |  |  | Mitral Valve Prolapse  |  |  | Low Blood Pressure  |  |  |
| Bruise Easily  |  |  | Heart Attack/Failure  |  |  | Pain in Jaw Joints  |  |  | Tumors or Growths  |  |  |
| Cancer  |  |  | Heart Murmur  |  |  | Osteoporosis  |  |  | Ulcers  |  |  |
| Chemotherapy  |  |  | Heart Pacemaker |  |  | Heart Trouble/Disease  |  |  | Venereal Disease  |  |  |
| Rheumatic Fever  |  |  | Frequent Headaches  |  |  | Psychiatric Care  |  |  | Cortisone Medicine  |  |  |
| Hepatitis A |  |  | Hemophilia  |  |  | Diabetes  |  |  | Hepatitis B or C  |  |  |
| Congenital Heart Disorder  |  |  | Radiation Treatments  |  |  | Recent Weight Loss  |  |  | Cold Sores/Fever Blisters |  |  |
| Convulsions  |  |  |  |  |  | Renal Dialysis  |  |  |  |  |  |

Have you ever had any serious illness not listed above? Yes ( ) No ( ) If yes, please explain:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Doctor’s Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To the best of my knowledge, the questions on this form have been accurately answered.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_\_\_\_

Signature of Patient, Parent, or Guardian Date:

**DENTAL HISTORY**

Patient Initials: \_\_\_\_\_\_ Birthdate: \_\_\_/\_\_\_/\_\_\_\_\_\_\_

How would you rate the condition of your mouth? ( ) Excellent ( ) Good ( ) Fair ( ) Poor

When was last dental exam? ( ) 6 months ago ( ) 1 year ago ( ) more than a year ago ( ) a long time ago

Last x-rays: ( ) 6 months ago ( ) 1 year ago ( ) more than a year ago ( ) a long time ago

I routinely see the dentist every: ( ) 3 months ( ) 4 months ( ) 6 months ( ) 12 months ( ) Not routinely

What is your immediate concern? ­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
|  |
| **DENTAL ANXIETY** | **Yes**  | **No** |
| Are you fearful of dental treatment?  |  |  |
| Have you had an unfavorable dental experience? |  |  |
| Have you had complications from any past dental treatment? |  |  |
| Have you ever had trouble getting numb or had any reactions to local anesthetic? |  |  |
| If fearful of dental treatment, how much from 1 to 10? |  |
| Explain, please: |
|  |
| **OTHER DENTAL QUESTIONS** | **Yes**  | **No** |
| Is there anything about the appearance of your teeth you would like to change?  |  |  |
| Are you happy with the color of your teeth? |  |  |
| Have you felt uncomfortable or self-conscious about the appearance of your teeth? |  |  |
| Do you have problems with your jaw joint? (pain, sounds, limited opening, lock popping) |  |  |
| Is there anyone with a history of gum disease in your family? |  |  |
| Have your teeth changed in the last 5 years, become shorter, thinner or worn? |  |  |
| Are your teeth crowding or developing spaces? |  |  |
| Do you chew ice, bite your nails, use your teeth to hold objects or have any other oral habits? |  |  |
| Do you clench or grind your teeth in the daytime/nigh time or do they become sore? |  |  |
| Do you have any problems with sleep or wake up with an awareness of your teeth? |  |  |
| Do you wear or have you ever worn a bite appliance? |  |  |
| Have you had any cavities within the past 3 years? |  |  |
| Does your mouth feel dry or do you have any difficulty swallowing any food? |  |  |
| Are any teeth sensitive to hot, cold, biting, sweets? |  |  |
| Have you ever had broken teeth, chipped teeth, or had a toothache, or cracked filling? |  |  |
| Do you frequently get food caught between any teeth? |  |  |
| Do your gums bleed or are they painful when brushing or flossing? |  |  |
| Have you ever been treated for gum disease? |  |  |
| Have you ever noticed an unpleasant odor in your mouth? |  |  |
| Did you ever have braces, orthodontic treatment or have your bite adjusted? |  |  |
| Have you had any teeth removed? |  |  |
|  |  |
| **DENTAL HYGIENE** |
| How many times a day do you brush your teeth?  | ( ) once  | ( ) twice  | ( ) it varies |
| Do you floss your teeth?  | ( ) daily  | ( ) sometimes  | ( ) rarely | ( ) never |
| Doctor’s Notes: |



**HIPAA PATIENT CONSENT FORM**

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

• Protected health information may be disclosed or used for treatment, payment, or health care operations.

• The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.

• The Practice reserves the right to change the Notice of Privacy Practices.

• The patient has the right to restrict the uses of their information but the Practice does not have to agree to the restrictions.

• The patient may revoke this Consent in writing at any time and all future disclosures will then cease.

• The Practice may condition receipt of treatment upon the execution of this Consent.

The Consent was signed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_\_

 (Printed Name of Patient or Representative)

Relationship to Patient (if other than patient): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_\_

 (Printed Name . Practice Representative)

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**Financial Agreement**

Thank you for choosing Townsend Harbor Dental Care as your dental health care provider.

It is our goal to provide you and your family with optimal dental care. It is our goal for our patients to understand their treatment needs as well as their financial responsibility before treatment begins.

Please, review the following policies and procedures:

**Payment Policy:**

Payment is due at the time that services are rendered. If you have dental insurance, your estimated co-pay and deductible are due at the time of service.

1. We accept cash, personal checks with proper ID, Visa, MasterCard, American Express and Discover.

2. THDC Membership is as an alternative to dental insurance offered by Townsend Harbor Dental Care. Please, ask for details.

3. If there is a balance on your account for more than 30 days, a finance charge of 3% per month will be added to your account until the balance is paid in full.

4. To maintain regularly scheduled appointments, patients must not carry a balance older than 90 days. Emergency services will be provided on a fee for service basis.

5. You will be responsible for all costs incurred in the collection of your debt such as collection agency fees, court fees and or attorney fees.

6. A fee of $35.00 will be applied to your account in the event a check is returned by your bank.

**Dental Insurance**: As a *courtesy*, we will file your claims and accept assignment of dental insurance benefits provided you agree to the following:

1. You must provide us with an insurance card and/or all information necessary to verify your coverage and file your claim.

2. Your insurance policy is a contract between you, your employer, and the insurance company. Townsend Harbor Dental Care is not a party to that contract. Our relationship is with you, not your insurance company, therefore there will be times that you will need to interact with your insurance directly.

3. Although we may estimate your insurance benefits and copays, we are not responsible for their accuracy. ***Knowledge of your benefits as well as benefit amounts, limitations, exclusions, waiting periods etc. is entirely your responsibility***. Receiving our services indicates your acceptance of responsibility to pay regardless of our estimate. You can reach out to your insurance company for any questions.

4. All charges not paid by your insurance company *are your responsibility regardless of the reason for non-payment*. Not all services we provide are covered benefits. Benefits differ from one insurance company to another. Fees for non-covered services, along with deductibles and copayments are due at the time of treatment. Townsend Harbor Dental Care does not determine what your covered insurance benefit will be – the dental insurance plan you chose determines it.

5. Treatment provided in another office during your current plan year may alter your co-payment due for services in our office. In such cases, we are not able to track whether you have reached your yearly maximum benefits. Please call your insurance company if this applies to you. When determining benefit coverage. How often procedure can be done also affects coverage.

6. There are many factors in determining patient responsibility where coordination of benefits between two insurance companies is involved. We will provide you with the most accurate information available to us but cannot guarantee what your out of pocket expense will be, but we will try to estimate it to the best of our abilities,

7. Please understand that our responsibility is to provide you with treatment that best meets your needs, not to match your care to insurance plan limitations.

**Minor Patients:** In a case of divorced or separated parents, it is your responsibility to have financial arrangements made before the treatment begins. Payments for services for the treatment of minors is the responsibility of adult accompanying the minor and will be due at the time of service.

**Missed appointments:** To avoid a missed appointment fee of $50.00, call the office if you need to reschedule or cancel your appointment. We appreciate **48 hour notice** to reschedule. We reserve the right to terminate professional treatment for any patient when scheduled appointments are not kept.

I have read and understand this document outlining the financial policies for Townsend Harbor Dental Care and agree to these terms. For the mutual convenience of you and the practice, it is understood that this executed copy of the Financial Agreement shall cover your dependent children who are patients of the practice.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name of Patient or Parent/Guardian

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_\_\_\_

Signature of Patient or Parent/Guardian Date