Medical and Dental Health History Form

Date: ____________________

Patient name (first and last): ____________________

Name of previous dentist/location: ____________________

Date of last dental examination: ____________________

Date of last cleaning: ____________________

Why have you come to see us today (e.g. pain, checkup, etc.)? ____________________

____

____

Name and contact information for family physician: ____________________

____

Dental Health:

Yes	No	
☐	☐	Do you brush your teeth? How often? ____________________
☐	☐	Do you floss? How often? ____________________
☐	☐	Are you having any pain or discomfort at this time?
☐	☐	Do your gums bleed while brushing and flossing?
☐	☐	Are your teeth sensitive to hot or cold liquids/foods?
☐	☐	Have you ever experienced any of the following problems with your jaw?

(Circle all that apply): clicking pain difficulty in opening and closing difficulty in chewing

Yes	No	
☐	☐	Do you have frequent headaches?
☐	☐	Do you clench or grind your teeth? If yes, when? ____________________
☐	☐	Have you ever had any orthodontic treatment? If so, do you wear a retainer? ____________________
☐	☐	Have you ever had facial surgery? If so, when and what area of your face? ____________________
☐	☐	Have you ever had any type of trauma to your mouth, jaw or face? If yes, describe: ____________________
☐	☐	Do you wear dentures or partials? If so, date of placement: ____________________
☐	☐	Do you have any concerns about bad breath odor?
☐	☐	Are you pleased with the appearance of your teeth when you smile?
☐	☐	Are you pleased with the color of your teeth?
☐	☐	Is there any dental treatment you are not happy with?
☐	☐	Are you nervous about dental treatment?

Medical Health:

Are you allergic or have you reacted adversely to any of the following (check all that apply):

_____ Aspirin
_____ Codeine
_____ Nitrous Oxide
_____ Penicillin
_____ Erythromycin
_____ Other antibiotics ___________________
_____ Latex, Metals, Plastic

____ Ibuprofen
____ Sulfa Drugs, Sulfites, Sulfides
____ Acetaminophen/Tylenol
____ Barbiturates
____ Tetracycline
____ Local Anesthesia (Novocaine)

Please list any other allergies to include medications you are allergic to:

Check any of the following that you have had or have at the present:

_____ Osteoporosis
_____ Heart disease or heart attack
_____ Abnormal blood pressure
_____ Heart murmur/mitral valve prolapse
_____ Rheumatic fever
_____ Heart pacemaker
_____ Heart surgery
_____ Stroke
_____ Kidney disease
_____ History of drug addiction /alchoholism
_____ Arthritis
_____ Anemia
_____ Bleeding disorders
_____ Hay fever
_____ Ulcers
_____ Jaundice
_____ Herpes
_____ Tumor or malignancy
_____ Radiation treatment
_____ Blood transfusion
_____ Fainting
_____ Headaches
_____ Glaucoma
_____ Shingles

____ Bisphosphonate therapy (e.g. Boniva)
____ Asthma
____ Diabetes
____ Thyroid issues
____ Hepatitis A, B, C
____ Hemophilia
____ Epilepsy or seizures
____ Psychiatric treatment
____ Artificial joints
____ Anemia
____ AIDS or HIV+
____ Congenital heart lesions
____ Tuberculosis or lung disease
____ Sinus issues
____ Liver disease
____ Infectious mononucleosis (mono)
____ Sexually transmitted/venereal disease
____ Cancer/chemotherapy/radiation
____ Implants/artificial joints
____ Anaphylaxis
____ Allergies (including food)
____ Hard of hearing
____ Sickle cell disease/traits

Other: ____
____

Major surgeries (type and year): ____
____
____
____

List sports activities: ____
____
____

Please list all medications you are currently taking, including prescription drugs, over-the-counter drugs, vitamins, herbal remedies and supplements. (An example is listed below.)

Name of medication	Dosage in mg.	Number of times taken	When (daily, as needed)
i.e. Aleve	275	2x	daily

____

____

____

____

____

____

Yes	**No**	
☐	☐	Have you been hospitalized during the past two years?
☐	☐	Have you been asked by your medical doctor to premedicate before any dental treatment?
☐	☐	Have you taken Fen-Phen, Redux or appetite suppressants? If yes, have you seen a physician for a cardiac evaluation?
☐	☐	Do you have any disease, condition or problem not listed?
☐	☐	Do you smoke or use chewing tobacco?
☐	☐	Do you smoke or ingest marijuana?
☐	☐	Do you drink alcohol? If yes, how often and in what quantity?

For Women Only:

Yes	**No**	
☐	☐	Are you pregnant? If yes, due date: ____________
☐	☐	Are you taking birth control pills?
☐	☐	Could you be pregnant?
☐	☐	Are you nursing?
☐	☐	Hormone replacement?

This form is designed to solicit information typically required to plan treatment. The space below is for you to tell me other information you believe I should take into account when planning your treatment.

____

____

____

____

____

In the event of an emergency please contact:

Name: Relationship: ________________________________ ________________________________

Phone:

If you have any questions about this form or are unsure how to answer any questions, we'd be happy to assist you, please ask!

Authorization: I have reviewed the information on this form and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status I will inform the dentist.

Signed: Date: ______________________________

Patient Review and Update of Form: At each visit please review this form, note any changes, sign and date in the spaces below:

HIPAA: Patient Acknowledgement and Consent Form

The federal law known as the Health Insurance Portability and Accountability Act of 1996 [HIPAA] requires that this office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future.

To comply with one of HIPAAs requirements, we are giving you a copy of our Notice of Privacy Practices. This Notice of privacy practices contains the information that HIPAA requires us to disclose regarding our privacy practices.

Existing Michigan Law requires [in addition to our attempt to obtain your written acknowledgement] us to first attempt your written consent prior to disclosing any of your information except for our disclosures in connection with a defense to a claim challenging our professional competence; a review entity's functions; a claim for payment of fees; a third party payer's examination of our records; a count order as part of a criminal investigation; an identification of a dead body; a licensure investigation; or a child abuse-neglect investigation.

From time to time it may be necessary for us to make disclosures of your information in connection with your treatment e.g., a referral to or consult with another dentist or health care professional, a specimen to a laboratory for testing or otherwise make disclosures of your information in connection with providing or coordinating your treatment.

Patient Acknowledgement

____

Patient Signature　　　Patient Name [Please Print]　　　Date

Patient Consent

Please sign this form to "Consent" to our disclosures of your information, that we may deem necessary in order to provide you with proper treatment.

I consent to your disclosures of my information, which you deem are necessary in connection with my treatment. I understand that disclosures may not be the type listed above. In addition, I consent to communicating with the family member(s) and/or other individuals listed below regarding appointment(s) and treatment.

____

Name　　　Relationship to Patient　　　Phone Number

____

Patient Signature　　　Patient Name [Please Print]　　　Date

Financial Policy Form

Dear Patient:

Thank you for choosing Twin Oaks Dental Studio to service your dental care needs. It is our privilege to be your dental health care provider and we appreciate the trust that you have given us. We are committed to providing only the best dental care. In order to give you the best experience possible, we have found that when everyone is clear on payment for treatment, then confusion and misunderstanding is kept to a minimum.

The following is our Financial Policy. Our main concern is that you receive the proper and optimal treatment needed to restore and maintain your dental health. Therefore, if you have any questions or concerns about our payment policies please do not hesitate to contact our office staff. We ask that all patients read and sign our financial document as well as complete our Patient Intake Forms prior to seeing the doctor.

Payment for services is due at the time services are rendered. If insurance is expected to pay a portion (or all) of the amount due, then an estimate of your portion will be provided prior to services being rendered and will be due at time of service. We accept cash, personal checks, and for your convenience, MasterCard, Visa, Discover, and American Express. We also accept CareCredit (please ask how we can help with your application). We will be happy to process your insurance claim for you at each visit.

In some instances, we may accept assignment of benefits. Please ask the office staff if we participate with your insurance carrier. However, you must understand that if we do not participate with your insurance carrier:

1. Your insurance policy is a contract between you, your employer, and the insurance company. We are NOT a party to that contract. Our relationship is with you, not your insurance company.
2. All charges are your responsibility whether your insurance company pays or not. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. This does not mean it is not the treatment you need.
3. Fees for these services, along with unpaid deductibles and co-payment, are due at the time of treatment. If payment arrangements have to be made, this must be done before treatment and approved by the office manager.
4. If the insurance company does not pay your balance in full within 30 days, we ask that you contact the insurance carrier to help speed things up.
5. **If the insurance company does not pay your balance in full within 45 days, we require you to pay the balance due with cash, personal check, MasterCard, Visa, Discover, or American Express.**
6. Returned checks will be subject to a $25 collection fee.
7. All balances older than 60 days will be reviewed and turned over to collection.

We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems so that we may assist you in the management of your account.

We also understand that dental care can be costly; therefore, we do our best to keep our fees as low as possible. We appreciate your assistance in helping to keep our costs to a minimum by taking care of your financial obligations when services are rendered. **We respect your time, please respect ours. To avoid a missed appointment fee, we require at least a 48-hour notice.** Otherwise, please note that should you fail to show for your appointment or fail to cancel your scheduled appointment within forty eight (48) hours of the scheduled appointment time, you may be subject to a charge as follows: Hygienist: $75/hr., Dentist: $150/hr.

Again, thank you for choosing Twin Oaks Dental Studio as your dental healthcare provider. We appreciate your trust and we appreciate the opportunity to serve you.

Patient's name (print):______________________________ Date ______________

Patient's signature: ______________________________ Date ______________

Patient's guardian: ______________________________ Date ______________