Health History Form

Date ___________________

Name________________________________ Home Phone (____)_____________ Cell (____)_______________ Work (____)_______________

Address______________________________ City ________________________ State _________________ Zip Code______________________

Occupation___________________________ Height ___________ Weight ___________ Date of Birth _______________ Sex ☐ M ☐ F

SS#____________________ Emergency Contact______________________ Relationship________________ Phone (____)_______________

E-mail Address__________________________Who referred you to our practice? ____

Name relationship

DENTAL INFORMATION

Please select the level of care you desire from our office:

☐ Emergency care as needed
☐ Consultation to solve a specific problem or issue
☐ Routine examination and preventative care
☐ Comprehensive care, optimal dental health and appearance

List the 3 most important factors you desire from your dental office?

____

____

____

How would you describe your current dental situation?____

Date of your last dental appointment?____

What was done at that time? ____

How do you feel about the appearance of your teeth?_________________________________ Do you have any problems with bad breath?________

YES	NO	UNSURE	
☐	☐	☐	Do your gums bleed when you brush?
☐	☐	☐	Are your teeth sensitive to cold, hot, sweets, or pressure?
☐	☐	☐	Have you had any periodontal (gum) treatments?
☐	☐	☐	Have you ever had orthodontic treatment?
☐	☐	☐	Do you have headaches, earaches or neck pains?
☐	☐	☐	Do you wear removable dental appliances?
☐	☐	☐	Have you had any serious/difficult problem associated with any previous dental treatment? If so, explain________________

____

MEDICAL INFORMATION

YES	NO	UNSURE	
☐	☐	☐	Are you in good health?
☐	☐	☐	Have there been any changes in your health within the past year?____
☐	☐	☐	Are you under the care of a physician? If so, what are the conditions being treated?_______________________________________

____Date of last exam______________

Physician(s)____

Name Phone Address City/State/Zip

____

Name Phone Address City/State/Zip

YES	NO	UNSURE	
☐	☐	☐	Have you ever had any serious illness, operation, or been hospitalized in the past five years? If so, what was the illness or problem?____
☐	☐	☐	Do you wear contact lenses?
☐	☐	☐	Do you drink alcoholic beverages? If yes, how much alcohol did you drink in the past week?_______month?_________ If yes, _________# drinks per day for _________# of years
☐	☐	☐	Are you alcohol and/or drug dependent? If so have you received treatment? (check one) ☐ YES ☐ NO
☐	☐	☐	Do you use drugs or other substances for recreational purposes? If yes, please list _________________________________
☐	☐	☐	Do you use tobacco (smoking or chew)? If so, how interested are you in quitting? ☐ Very ☐ Somewhat ☐ Not at all How many years have or did you use tobacco? _________ How much tobacco did you use per day? ________________

Are you taking any medications? If yes, for what purposes? PLEASE LIST BELOW

NAME OF DRUG	PURPOSE	DOSE

Are you allergic to or have you had a reaction to?	YES	NO	UNSURE
Penicillin or other antibitoics	☐	☐	☐
Barbiturates, sedatives, or sleeping pills	☐	☐	☐
Sulfa Drugs	☐	☐	☐
Codeine or other narcotics	☐	☐	☐
Latex	☐	☐	☐
Iodine	☐	☐	☐
Hay fever/seasonal	☐	☐	☐
Other (specify)_________________________			

Please (x) a response to indicate if you have or have had any of the following diseases or problems

	YES	NO	UNSURE
Abnormal Bleeding	☐	☐	☐
AIDS or HIV	☐	☐	☐
Anemia	☐	☐	☐
Arthritis	☐	☐	☐
Rheumatoid Arthritis	☐	☐	☐
Asthma	☐	☐	☐
Blood transfusion If yes, date__________	☐	☐	☐
Cancer/Chemotherapy/Radiation	☐	☐	☐
Cardiovascular diseases? If yes, please specify	☐	☐	☐
_____Angina Pectoris			
_____ Heart murmur			
_____Bypass Sugery			
_____Mitral Valve Prolapse			
_____Pacemaker			
_____Rheumatic fever			
_____High Blood Pressure			
_____Artificial valves			
_____Heart attack Date________			
Chest Pain upon exertion	☐	☐	☐
Chronic Pain	☐	☐	☐
Disease, drug, or radiation-induced immunosuppression	☐	☐	☐
Diabetes. If yes, please specifiy	☐	☐	☐
______Insulin dependent ______ Non-Insulin dependent			
Dry mouth	☐	☐	☐
Eating disorder. If yes, please specify_______________	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Gastrointestinal Disease	☐	☐	☐
G.E. reflux/persistent heartburn	☐	☐	☐
G. Glaucoma	☐	☐	☐
Kidney Disease/	☐	☐	☐

	YES	NO	UNSURE
Hemophilia	☐	☐	☐
Hepatitis, Jaundice, or Liver Disease	☐	☐	☐
Reccurent Infection	☐	☐	☐
If yes, indicate type of infection_______			
Mental Health disorder	☐	☐	☐
Night Sweats	☐	☐	☐
Neurological disorders	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistant swollen glands	☐	☐	☐
Respiratory problems.	☐	☐	☐
If yes, please specify: ___Emphysema ___Bronchitis, etc.			
Severe headaches/migraines	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Sexually transmitted Disease	☐	☐	☐
Sinus Trouble	☐	☐	☐
Sores or ulcers in the mouth	☐	☐	☐
Stroke	☐	☐	☐
If yes, date_________			
Systemic Lupus Erythematosus	☐	☐	☐
Tuberculosis	☐	☐	☐
Thyroid problems	☐	☐	☐
Ulcers	☐	☐	☐
Excessive urination	☐	☐	☐
Joint replacement	☐	☐	☐
Do you have any disease not listed above that you think we should know about?	☐	☐	☐
Please Explain:_________________________________			
Have you ever been told you needed to premedicate before your dental appointment?	☐	☐	☐

I certify that I have read and understand the above. 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 because of errors or ommission that I may have made in the completion of this form.

____ ______________________

SIGNATURE OF PATIENT/LEGAL GUARDIAN DATE

Name of Responsible Party: _____________________________________ Social Security #: ________________

DOB: ______________ Relationship to patient: _______________ Phone: _____________________________

Address: ____

Name of Insured: ____ DOB: _______________________

Employers Name: ____ Group #: ______________________________

ID #: ____________________________________ Insurance Company: __________________________________

Insurance Company Address: ____

Insurance Company Phone #: ____________________________

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the cost incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. The office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the doctor, I agree to pay therefore the reasonable value of said services to said doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

All estimated co-payments are due at the time the service is rendered unless otherwise is stated in advance. Different insurance companies may vary in co-payments and additional charges may be applied.

Please keep in mind cancelled appointments and no shows are subject to a $65 charge. Also returned checks will be assessed a $35 fee.

I have read the above conditions of treatment and payment and agree to their content.

Signature of Patient: ____ Date: ____________________________

Communication Preference

Please communicate via: Home Phone: Y / N Mobile Phone: Y / N

Phone # to use: (_____) ______ - __________

My Preferred Method of Communication is: Text message: Y / N Short phone call Y / N

* Text message requires mobile # (_____) ______ - __________

E-Mail Option: Please copy messages and appt. reminders via e-mail Y / N

E-Mail Address _______________________________________

I authorize Malcolm J Murray, DDS to contact me via direct mail, e-mail, mobile text message (standard txt & data rates may apply), or telephone (including pre-recorded telephone calls) for purposes of appointment reminders, health messages or current in-office specials that may be of interest to me. I understand that I can opt-out of these communications at any time by informing the front desk.

Patient Name: _____________________________ Patient Signature: _________________________

Insurance Policy

We do our best to provide you with the closest estimate for your treatment. We gather the percentages for procedures and the insurance fees (if in-network applies) for each procedure. It is ultimately up to you to know your insurance plan coverage. If a procedure is denied or your portion is higher than what is estimated you will be responsible for the charges.

Issues you should know that can reflect procedure coverage:

- Waiting period
- Downgrade to silver/gold restorations on back teeth
- Missing tooth clause
- Pocket depths not high enough for benefits
- Frequency of procedure
- Annual maximum met

Please feel free to discuss these situations with us if you have any questions regarding the issues above.

Patient Signature: _________________________________ Date:___________________