

Health History Form

ADA American Dental Association®

America's leading advocate for oral health

Email:

Today's Date:

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name:			Home Phone: Include area code		Business/Cell Phone: Include area code	
Last	First	Middle	()		()	
Address:			City:		State: Zip:	
Mailing address						
Occupation:			Height:	Weight:	Date of Birth:	Sex: M F
Emergency Contact:			Relationship:	Home Phone: Include area code	Cell Phone: Include area code	
				()	()	
If you are completing this form for another person, what is your relationship to that person?						
Your Name			Relationship			
Do you have any of the following diseases or problems:			(Check DK if you Don't Know the answer to the the question)			Yes No DK
Active Tuberculosis.....						<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Persistent cough greater than a 3 week duration.....						<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Cough that produces blood.....						<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Been exposed to anyone with tuberculosis.....						<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.						

Dental Information For the following questions, please mark (X) your responses to the following questions.

Yes No DK		Yes No DK	
Do your gums bleed when you brush or floss?.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you have earaches or neck pains?.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Are your teeth sensitive to cold, hot, sweets or pressure?.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you have any clicking, popping or discomfort in the jaw?.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Is your mouth dry?.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you brux or grind your teeth?.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Have you had any periodontal (gum) treatments?.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you have sores or ulcers in your mouth?.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Have you ever had orthodontic (braces) treatment?.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you wear dentures or partials?.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Have you had any problems associated with previous dental treatment?.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you participate in active recreational activities?.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Is your home water supply fluoridated?.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Have you ever had a serious injury to your head or mouth?.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Do you drink bottled or filtered water?.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Date of your last dental exam:	
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY		What was done at that time?	
Are you currently experiencing dental pain or discomfort?.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Date of last dental x-rays:	
What is the reason for your dental visit today?			
How do you feel about your smile?			

Medical Information 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	
Are you now under the care of a physician?.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Have you had a serious illness, operation or been hospitalized in the past 5 years?.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Physician Name:	Phone: Include area code	If yes, what was the illness or problem?	
	()		
Address/City/State/Zip:		Are you taking or have you recently taken any prescription or over the counter medicine(s)?.....	
		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Are you in good health?.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements:	
Has there been any change in your general health within the past year?.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		
If yes, what condition is being treated?			
Date of last physical exam:			

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	(Check DK if you Don't Know the answer to the question)		Yes No DK	
Do you wear contact lenses?.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you use controlled substances (drugs)?.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you use tobacco (smoking, snuff, chew, bidis)?..... If so, how interested are you in stopping? Circle one: VERY / SOMEWHAT / NOT INTERESTED		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Date: _____ If yes, have you had any complications? _____			Do you drink alcoholic beverages?.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax®, Actonel®, Atelvia®, Boniva®, Reclast®, Prolia®) for osteoporosis or Paget's disease?.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	If yes, how much alcohol did you drink in the last 24 hours? _____			
Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia®, Zometa®, XGEVA®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	If yes, how much do you typically drink in a week? _____			
Date Treatment began: _____			WOMEN ONLY Are you:			
			Pregnant?.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
			Number of weeks: _____			
			Taking birth control pills or hormonal replacement?.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
			Nursing?.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Allergies. Are you allergic to or have you had a reaction to: To all yes responses, specify type of reaction.			Yes No DK	Metals _____		Yes No DK
Local anesthetics _____			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Latex (rubber) _____		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Aspirin _____			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Iodine _____		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Penicillin or other antibiotics _____			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Hay fever/seasonal _____		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Barbiturates, sedatives, or sleeping pills _____			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Animals _____		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Sulfa drugs _____			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Food _____		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Codeine or other narcotics _____			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Other _____		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
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.....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Autoimmune disease.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Previous infective endocarditis.....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Rheumatoid arthritis.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Damaged valves in transplanted heart.....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Systemic lupus erythematosus.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Congenital heart disease (CHD)				Asthma.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Unrepaired, cyanotic CHD.....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Bronchitis.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Repaired (completely) in last 6 months.....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Emphysema.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Repaired CHD with residual defects.....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Sinus trouble.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.						
Yes No DK			Yes No DK		Yes No DK	
Cardiovascular disease.....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Mitral valve prolapse.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Angina.....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Pacemaker.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Arteriosclerosis.....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Rheumatic fever.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Congestive heart failure.....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Rheumatic heart disease.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Damaged heart valves.....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Abnormal bleeding.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Heart attack.....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Anemia.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Heart murmur.....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Blood transfusion.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Low blood pressure.....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	If yes, date: _____		
High blood pressure.....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Hemophilia.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Other congenital heart defects.....			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	AIDS or HIV infection.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
			<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Arthritis.....		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?.....						<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
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?.....						<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Please explain:						

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

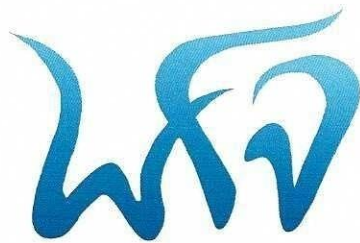
I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries 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: _____



Wilbraham Family Dentistry

FINANCIAL POLICY

The following is a statement of our financial policy. A copy of this policy will be given to you if requested.

- Full payment is due at the time of service.
- For your convenience we accept, Visa, MasterCard, Discover, American Express, CareCredit, personal checks and cash.

REGARDING INSURANCE ASSIGNMENT

Contact your insurance company to make certain that you have an understanding of your dental coverage. Most insurance companies pay only a portion of dental treatment. If you have a dental procedure done outside this office it will impact your yearly maximum and insurance payments to us.

- As a courtesy to our patients, we accept assignment of insurance benefits, however, your insurance co-payment (patient portion) is due at time of service.
- The patient must assume full responsibility for any fees not covered by their insurance. Your balance is your responsibility, whether your insurance company pays or not.
- Your insurance benefit is a private contract between you and your insurance company. Wilbraham Family Dentistry is not a party of that contract.
- The insurance payment estimate provided by this office is a guideline.
- We cannot bill your insurance unless you provide all insurance information.

MISSED APPOINTMENTS

When you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment.

- No charge will be made for rescheduling or cancelling appointments provided 24-hour notice is given.
- If less than a 24 hour notice of cancellation or a no-show for an appointment, patient may be subject to a \$50 fee. Fees are the patient's sole responsibility and must be paid before your next appointment.
- If a patient is more than 15 minutes late for an appointment, the appointment may have to be rescheduled if there is not enough time to complete the procedure.

I certify I have read, understand and agree with this policy.

Signature: _____ Date: _____



Wilbraham Family Dentistry

Dental Insurance Information

Name of person carrying primary DENTAL insurance: _____

Birth Date: _____ Employed by (or Retired from): _____

Employer's Address: _____

Primary Dental Insurance Company: _____ ID#/SS#: _____ Group #: _____

IF you have a second dental insurance policy, please fill out the following:

Name of person carrying Secondary Dental insurance: _____

Birth Date: _____ Employed by (or Retired from): _____

Secondary Insurance Company: _____ ID#/SS#: _____ Group #: _____

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 patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services or any dental services performed without previous financial arrangements must be paid for at the time services are performed.

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. This office will help prepare the patient's 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 by the Doctor, I agree to pay the reasonable value of said services to said Doctor or his assignee at the time 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 payments 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 such be instituted hereunder.

I grant my permission to you or your assignee to telephone me at home or at my work to discuss matters related to this form.

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

Signature of patient, parent or guardian Date _____ Relationship to patient _____

Signature of guarantor of payment/responsible party Date _____ Relationship to patient _____



Authorization to Share Medical Information

Your Right to Medical Information Confidentiality Under HIPAA

HIPAA (Health Insurance Portability and Accountability Act of 1996) states if you are 18 years or older, you have the right to strict confidentiality regarding your visits to Wilbraham Family Dentistry, LLC. In order to release any information including the date or nature of your visit, Wilbraham Family Dentistry, LLC must have your signed consent and specific directions about what information you are consenting to be released. Without written consent, Wilbraham Family Dentistry, LLC cannot release or discuss any information relating to your visit with anyone not directly related to your case. In addition, you have the right to revoke this authorization at any time. Revocation will be effective when Wilbraham Family Dentistry, LLC receives written notice that this authorization has terminated. A copy of this document will be kept in your health record.

Patient's name: (please print) _____

Date of Birth: ____/____/____

In signing this authorization to release my protected health information, I acknowledge that I have read and understand my rights to medical information confidentiality and authorize Wilbraham Family Dentistry, LLC to discuss health issues with the following listed individuals:

_____ Relationship: _____

_____ Relationship: _____

_____ Relationship: _____

Signature/Date



RELEASE OF RECORDS REQUEST

I hereby request all dental records, including radiographs, daily treatment notes and contact information, from the office of:

Please send my records to:

**Wilbraham Family Dentistry
85 Post Office Park, Suite 8503
Wilbraham, MA 01095
Phone: 413-596-3881**

X-rays may be emailed to info@wilbrahamfamilydentistry.com

Signature of Patient: _____

Patient's Name (print): _____

Address: _____

Date: _____