Health History Form

E-mail: Today's Date:

Pinnacle DENTAL

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*

Address: City: State: NV Zip:

Occupation: Height: Weight: DOB: Sex: Male

SS# or Patient ID: Emergency Contact: Relationship: Home Phone: *(include area code)* Cell Phone:

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 N/A if the question does not apply to you)**	**Yes**	**No**	**N/A**
Active Tuberculosis	☐	☐	☐
Persistent cough greater than a 3 week duration	☐	☐	☐
Cough that produces blood	☐	☐	☐
Been exposed to anyone with tuberculosis	☐	☐	☐

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	N/A
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Does food or floss catch between your teeth?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐
Have you had orthodontic treatment?	☐	☐	☐
If NO, are you interested in discussing orthodontic treatment?	☐	☐	☐
Are you currently experiencing dental pain or discomfort?	☐	☐	☐

	Yes	No	N/A
Do you have earaches or neck pain?	☐	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Do you brux or grind your teeth?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Do you participate in active recreational activities?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐

Date of your last dental exam:

What was done at that time?

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	N/A
Are you now under the care of a physician?	☐	☐	☐

Physician Name: Phone: *include area code*

Address/City/State/Zip

Are you in good health?	☐	☐	☐
Has there been any change in your general health within the past year?	☐	☐	☐

If yes, what condition is being treated?

Date of last physical exam:

	Yes	No	N/A
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐	☐

If yes, what was the illness or problem?

Are you taking or have you recently taken any prescription or over the counter medicine(s)?	☐	☐	☐

If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements:

Medical Information

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

(Check N/A if you Don't Know the answer to the question) **Yes No N/A**

Do you wear contact lenses?

Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?

Date: If yes, have you had any complications?

Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease?

Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia or Zometa) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?

Date Treatment began:

Yes No N/A

Do you use controlled substances (drugs)?

Do you use tobacco (smoking, snuff, chew, or bidis)?

If so, how interested are you in stopping?

(Circle one) VERY / SOMEWHAT / NOT INTERESTED

Do you drink alcoholic beverages?

If yes, how much alcohol did you drink in the last 24 hours?

If yes, how much do you typically drink in a week?

WOMEN ONLY Are you:

Pregnant?

Number of weeks:

Taking birth control pills or hormonal replacement?

Nursing?

Allergies - Are you allergic to or have you had a reaction to: **Yes No N/A**

To all yes responses, specify type of reaction.

Local anesthetics

Aspirin

Penicillin or other antibiotics

Barbiturates, sedatives, or sleeping pills

Sulfa drugs

Codeine or other narcotics

Yes No N/A

Metals

Latex (rubber)

Iodine

Hay fever/seasonal

Animals

Food

Other

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

Yes No N/A

Artificial (prosthetic) heart valve

Previous infective endocarditis

Damaged valves in transplanted heart

Congenital heart disease (CHD)

- Unrepaired, cyanotic CHD
- Repaired (completely) in last 6 months
- Repaired CHD with residual defects

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

Yes No N/A

Cardiovascular disease

Angina

Arteriosclerosis

Congestive heart failure

Damaged heart valves

Heart attack

Heart murmur

Low blood pressure

High blood pressure

Other congenital heart defects

Mitral valve prolapse

Pacemaker

Rheumatic fever

Rheumatic heart disease

Abnormal bleeding

Anemia

Blood transfusion

If yes, date:

Hemophilia

AIDS or HIV infection

Arthritis

Yes No N/A

Autoimmune disease

Rheumatoid arthritis

Systemic lupus erythematosus

Asthma

Bronchitis

Emphysema

Sinus trouble

Tuberculosis

Cancer/Chemotherapy/ Radiation Treatment

Chest pain upon exertion

Chronic pain

Diabetes Type I or II

Eating disorder

Malnutrition

Gastrointestinal disease

G.E. Reflux/persistent heartburn

Ulcers

Thyroid Problems

Stroke

Yes No N/A

Glaucoma

Hepatitis, jaundice or liver disease

Epilepsy

Fainting spells or seizures

Neurological disorders

If yes, specify

Sleep disorder

Mental health disorders

Specify:

Recurrent Infections

Type of infection:

Kidney problems

Night sweats

Osteoporosis

Persistent swollen glands in neck

Severe headaches/ migraines

Severe or rapid weight loss

Sexually transmitted disease

Excessive urination

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?

Name of physician or dentist making recommendation: Phone:

Do you have any disease, condition, or problem not listed above that you think I should know about?

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 reply 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:

FOR COMPLETION BY DENTIST

Comments:

Consent for Services

As condition of 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. Financial responsibilities on the part of each patient must be determined before treatment.

Patients with dental insurance understand that all dental services 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 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 any fee estimate 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 this practice, I agree to pay the charges for the services at the time of treatment. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. 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 costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

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

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

_____ ☑ I give permission for the dentist and the clinical team to take any necessary x-rays, photos, and study models to enable complete diagnosis and treatment.

_____ ☐ I authorize the dentist to release all information necessary to secure the payment of benefits. I understand I am financially responsible for all charges whether or not paid by insurance.

_____ ☐ I understand if I do not give a 24-hour notice to cancel my appointment I will be charged $25 for a missed appointment fee.

_____ ☐ I understand that if I am 15 minutes or more late to my confirmed appointment I will forgo my given appointment time and be charged one half of the total fee for that office visit.

These policies are subject to change without notice.

Signature of patient, parent, or guardian (responsible party):

Signature: _____ Date: _____

Insurance Verification

Pinnacle DENTAL

PATIENT NAME | DATE

HOME PHONE | WORK PHONE

SSN | DATE OF BIRTH

PLEASE FILL IN THE FOLLOWING DETAILS CAREFULLY

INSURED PERSONS NAME:

PATIENTS RELATION TO THE INSURED:

POLICY #: | GROUP #:

DATE OF BIRTH OF INSURED:

INSURANCE COMPANY NAME:

INSURANCE COMPANY NUMBER:

EFFECTIVE DATE OF INSURANCE:

PATIENT SIGNATURE | INSURED SIGNATURE | DATE