

HEIGHTS DENTAL CENTER

CRAIG MARTIN, DMD

PATIENT INFORMATION (Please Print Clearly)

Name of Patient _____ SS# _____
Address _____ Apt. # _____ City _____ State _____ Zip _____
Home Phone _____ Work Phone _____ Cell Phone/Other _____
Date of Birth _____ Age _____ Sex _____ Race _____ Marital Status _____
E-Mail Address _____ Employer _____ Position _____

HOW DID YOU HEAR ABOUT OUR OFFICE? Check all that apply:

Google Search Social Media Mailer Website Doctor/Insurance Office location
 Friend/Existing Patient (Name: _____) Other _____
(Please Specify)

Parent or Responsible Party (if patient is under age 18)

Mother/Guardian's Name _____	Father/Guardian's Name _____
Date of Birth _____ Marital Status _____	Date of Birth _____ Marital Status _____
Social Security No. _____	Social Security No. _____
Address _____ Apt. # _____	Address _____ Apt. # _____
City _____ State _____ Zip _____	City _____ State _____ Zip _____
Home No. _____ Cell No. _____	Home No. _____ Cell No. _____
Employer _____ Work No. _____	Employer _____ Work No. _____
E-Mail Address _____	E-Mail Address _____

Will the above party be responsible for any balance on the account? YES NO (circle one)

Will the above party be responsible for any balance on the account? YES NO (circle one)

Emergency Contact: _____ Phone No. _____
Relationship to Patient? _____

If the patient is covered by any dental insurance, please fill out the following:

Insurance Name _____	Insurance Phone No. _____
Employer _____ Phone No. _____	Group No. _____
Subscriber's Name _____	Subscriber's Date of Birth _____
Subscriber's SSN or ID # _____	Relationship to Patient _____
Rank (If Military) _____	Military Branch _____
Sponsor's Unit (If Military) _____	Unit Phone Number _____

If the patient is covered by a second insurance, please fill out the following:

Insurance Name _____	Insurance Phone No. _____
Employer _____ Phone No. _____	Group No. _____
Subscriber's Name _____	Subscriber's Date of Birth _____
Subscriber's SSN or ID # _____	Relationship to Patient _____
Rank (If Military) _____	Military Branch _____
Sponsor's Unit (If Military) _____	Unit Phone Number _____

CONSENT FOR SERVICES

I understand that forms for insurance claims will be submitted as long as I provide all the information necessary to complete filing. I authorize release of any information concerning the health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I hereby authorize payment of insurance benefits directly to the dentist. Staff will calculate ESTIMATED deductible and co-pay. Payment of this amount is due the day services are rendered. I understand that I am responsible for all costs of dental treatment within 30 days.

Patient or Legal Guardian's Signature: _____ Date: _____

HEALTH HISTORY FORM

As required by law (HIPAA), our office adheres to written policies and procedures to protect the privacy of information about you that we create receive or maintain. Please note that during your initial visit 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 _____ Height _____ Weight _____ Date of Birth ____/____/____ Sex M F
Last First Middle

Reason for today's visit? _____

Medical Information

ALLERGIES

Are you allergic to or have you had a reaction to any of the following? To all "Yes" responses specify type of reaction.

- | | | | | |
|--|--|----------------------------------|---|---|
| <input type="checkbox"/> Latex | <input type="checkbox"/> Local anesthetics | <input type="checkbox"/> Aspirin | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Codeine or other narcotics |
| <input type="checkbox"/> Metals | <input type="checkbox"/> Sulfa Drugs | <input type="checkbox"/> Foods | <input type="checkbox"/> Hay fever/seasonal | <input type="checkbox"/> Barbiturates, sedatives, or sleeping pills |
| <input type="checkbox"/> Any other allergies _____ | | | | <input type="checkbox"/> No Known Allergies |

If yes to any, please explain reaction: _____

WOMEN ONLY

Yes No Don't Know

- Are you pregnant? If yes, how many weeks? _____ Due Date: _____
- Taking birth control pills or hormonal replacement? _____ Nursing? _____

CONGENITAL HEART DISEASE / ARTIFICIAL JOINTS

Yes No Don't Know

- Artificial (prosthetic) heart valve
- Previous infective endocarditis
- Damaged valves in transplanted heart

Yes No Don't Know

- 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.

- Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? If so, when was this operation done? _____
- Have you had any complications or difficulties with your prosthetic joint? If yes, specify _____
- Has a physician or other dentist recommended you take antibiotics prior to dental treatment?**

Yes No Don't Know

- Are you taking or have you taken oral bisphosphonates? (Fosamax, Actonel, Boniva) or I.V. Bisphosphonates? (Actonel or Aredia) If so, for how long? _____
- Are you now under the care of a physician? If so, what is/are the condition(s) being treated? _____
 _____ Date last seen by this physician _____

Physician(s) _____
Name Phone Address City/State/Zip

- Are you taking or have you recently taken any medicine(s) including non-prescription medicine? If so, what are you taking?
 Prescribed _____
 Over the Counter/Herbal remedies _____

- Do you use tobacco (smoking, snuff)? If so, how interested are you in stopping? (Check one) Very Somewhat Not Interested

Yes	No	Don't Know
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Abnormal bleeding
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> AIDS or HIV infection
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Anemia
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Hemophilia
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Rheumatoid arthritis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Systemic lupus erythematosus
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Autoimmune disease
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Cancer / chemotherapy / radiation treatment
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Cardiovascular disease
		If yes, specify below:
		<input type="radio"/> Angina
		<input type="radio"/> Arteriosclerosis
		<input type="radio"/> Congestive Heart Failure
		<input type="radio"/> Damaged heart valves
		<input type="radio"/> Heart attack Date: _____
		<input type="radio"/> Heart murmur
		<input type="radio"/> High blood pressure
		<input type="radio"/> Low Blood Pressure
		<input type="radio"/> Mitral valve prolapse
		<input type="radio"/> Pacemaker
		<input type="radio"/> Rheumatic Fever
		<input type="radio"/> Rheumatic heart disease
		<input type="radio"/> Stroke Date: _____

Yes	No	Don't Know
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Chronic pain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Chest pain upon exertion
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Eating disorder
		If yes, specify _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Gastric reflux
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Gastrointestinal disease
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Ulcers
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Diabetes. If yes, specify:
		<input type="radio"/> Type I (Insulin dependent)
		<input type="radio"/> Type II
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Fainting spells or seizures
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Glaucoma
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Hepatitis, jaundice or liver disease
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Kidney Problems
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Mental health disorders
		If yes, specify _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Migraines / severe headaches
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Night Sweats
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Neurological disorders
		<input type="radio"/> Post Traumatic Syndrome (PTSD)
		<input type="radio"/> Traumatic Brain Injury (TB)
		<input type="radio"/> Other _____

Yes	No	Don't Know
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Persistent swollen glands in neck
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Respiratory problems.
		If yes, specify below:
		<input type="radio"/> COPD
		<input type="radio"/> Emphysema
		<input type="radio"/> Bronchitis, etc.
		<input type="radio"/> Asthma
		<input type="radio"/> Tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Severe or rapid weight loss
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Sexually transmitted disease
		If yes, specify _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Sinus trouble
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Sleep disorder
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Thyroid problems
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Do you have any disease, condition or problem not listed above that you think I should know about? Please explain:

Dental Information

Date of your last dental exam _____ Date of last dental x-rays _____

What was done at that time? _____

How do you feel about the appearance of your teeth? _____

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

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health. 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.

I authorize the taking of radiographs, study models, photographs, or other diagnostic aids deemed appropriate to aid in the diagnosis of my dental health.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf (if any).

Signature of Patient/Legal Guardian

Date

Relationship to Patient

For Completion by Dentist / Auxiliary

Comments: _____

Signature of Dentist / Auxiliary

Date