Health History Form

American Dental Association
www.ada.org

E-mail: 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: (Last First Middle) Home Phone: *Include area code* ( ) Business/Cell Phone: *Include area code* ( )

Address: (Mailing address) City: State: Zip:

Occupation: Height: Weight: Date of birth: Sex: M F

Emergency Contact: Relationship: Home Phone: ( ) Cell Phone: ( ) *Include area codes*

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 question)*	**Yes**	**No**	**DK**
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**	**DK**
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 ever had orthodontic (braces) treatment?	☐	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐
Do you drink bottled or filtered water?	☐	☐	☐
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY			
Are you currently experiencing dental pain or discomfort?	☐	☐	☐

	Yes	**No**	**DK**
Do you have earaches or neck pains?	☐	☐	☐
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**	**DK**
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**	**DK**
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 DK if you Don't Know the answer to the question)	**Yes**	**No**	**DK**
Do you wear contact lenses?	☐	☐	☐
Are you taking, or have you taken, any diet drugs such as Pondimin (fenflluramine), Redux (dexphenfluramine) or phen-fen (fenflluramine-phentermine combination)?	☐	☐	☐
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**	**DK**
Do you use controlled substances (drugs)?	☐	☐	☐
Do you use tobacco (smoking, snuff, chew, 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?	☐	☐	☐

Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? ☐ ☐ ☐
Date: _____ If yes, have you had any complications?

Allergies - Are you allergic to or have you had a reaction to:
To all **yes** responses, specify type of reaction.

	Yes	**No**	**DK**
Local anesthetics _____	☐	☐	☐
Aspirin _____	☐	☐	☐
Penicillin or other antibiotics _____	☐	☐	☐
Barbiturates, sedatives, or sleeping pills _____	☐	☐	☐
Sulfa drugs _____	☐	☐	☐
Codeine or other narcotics _____	☐	☐	☐
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**	**DK**
Heart murmur	☐	☐	☐
Mitral valve prolapse	☐	☐	☐
Artificial heart valves	☐	☐	☐
Rheumatic fever	☐	☐	☐
Cardiovascular disease	☐	☐	☐
Angina	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Congestive heart failure	☐	☐	☐
Coronary artery disease	☐	☐	☐
Damaged heart valves	☐	☐	☐
Heart attack	☐	☐	☐
Low blood pressure	☐	☐	☐
High blood pressure	☐	☐	☐
Congenital heart defects	☐	☐	☐
Pacemaker	☐	☐	☐
Rheumatic heart disease	☐	☐	☐
Abnormal bleeding	☐	☐	☐
Anemia	☐	☐	☐
Blood transfusion	☐	☐	☐
If yes, date: _____			
Hemophilia	☐	☐	☐
AIDS or HIV infection	☐	☐	☐
Arthritis	☐	☐	☐
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	☐	☐	☐
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 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:

FOR COMPLETION BY DENTIST

Comments: _____

Financial Policy

Thank you for choosing Essex Street Dental Medicine. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

- Visa, Mastercard, Cash, or Check

We offer a 5% courtesy accounting adjustment to patients who pay for their entire treatment with cash, check or credit card at time of service.

- NO INTEREST[1] Payment Plans[2] from CareCredit
    - Convenient, low monthly payment plans[2] also available for up to 60 months!
    - No annual fees or pre-payment penalties

Please note:

Essex Street Dental Medicine requires payment prior to the completion of your treatment, unless specific arrangements have been made in advance. Unpaid accounts accrue interest at the rate of 1.5% per month. Accounts that are unpaid for 60 days will be sent to collections and reported to the credit bureau.

If you choose to discontinue care before treatment is complete, any refund, if applicable, will be determined upon review of your case.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment (aka “assignment of benefits”).[3]

A fee of $50 is charged for patients who miss or cancel more than 2 times in a calendar year without 48 hours’ notice. Exceptions may be made for emergency circumstances.

Essex Street Dental Medicine charges $25 for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you receive the oral health care you need.

By signing below I acknowledge receipt and understanding these financial policies.

_____

Patient, Parent or Guardian Signature Date

_____

Patient Name (Please Print)

[1]If paid within the promotional period. Otherwise, interest assessed from purchase date. Minimum monthly payment required.

[2]Subject to credit approval

[3]However, if we do not receive payment from your insurance carrier within 60 days, you may be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.

Dental Insurance Policy Review

Please be aware that Dental Insurance is a contract between you, your employer, and the insurance company. It is designed as a company "benefit" to **help** you defray costs from dental work, but almost never **completely** pays for any necessary work. We submit claims to the companies as a courtesy to you—this is actually something that fewer and fewer offices are doing because of the time and financial costs involved.

We work very diligently to obtain accurate information as to your benefits, but you are ultimately responsible for understanding the benefits and limitations of your insurance policy.

Dental insurance companies may also substitute payment of any "White" or Composite filling with "Silver" or Amalgam fillings. Similarly, they could substitute payment of all-metal crowns for porcelain (matching) crowns. The insurance companies will often not actually disclose that composites are "not covered", only that an "alternate benefit is applied", meaning that they simply pay for the cheaper material. The difference between these materials is more than simply cosmetic, but this is beyond the scope of this document. These sorts of switches are known as "Allowances". A brief summary detailing some of these insurance company practices is available from Lucy if you would like to learn more about how insurance companies really work.

In these cases, the difference in cost between the service provided and what is reimbursed is the **responsibility of the patient**. We will do our best to let you know, as accurately as possible, what this amount will be prior to the appointment—but **please keep in mind that this is only an estimate and they may pay more or less than this amount**. This often happens if other claims are pending and they do not recognize this when we call them for up-to-the-minute information. This could result in a small credit on your account or an additional bill for the difference.

Please note that we will do everything in our power to maximize your utilization of benefits and make sure that they pay every penny to which you are entitled!

The Doctor, however, will not allow the insurance company, who will never see you in person, determine what you need and usurp his medical judgment.

I acknowledge receipt of the Essex Street Dental Medicine insurance policies and understand that, when appropriate, I am responsible for these differences in cost between services actually rendered, and what insurance companies arbitrarily decide.

Signature_____ Date_____

HIPAA and office Security Policies

This is the world's simplest and most straightforward Security Policy.

Basically, we take your privacy super seriously. Every employee has signed a document agreeing to abide by these rules and make sure you are protected.

- We will not share any information about you or your treatment with anyone else without your express written consent. Period.
- We don't even have a cleaning service. No one comes into contact with your information that is not a part of this practice and has not signed our pledge. The charts never physically leave the building.
- Your data that is stored is encrypted (and can only be read by our brand of software anyway).
- Even your credit card data is encrypted by our terminal.
- Any extraneous paper with potential secure information is pulped at a facility while Dr. Casiglia watches. Not "shredded", but actually rendered into tiny bits of pulp by a massive industrial machine. It's wicked.
- We never provide records to another office requesting them without your written release.

Clear-cut exceptions

- If you have insurance, obviously we must share treatment information with them to get the claims paid. But generally, you've given them your personal information already.
- If the government petitions us for information as part of an investigation, we may have to comply.
- If there are other legal proceedings surrounding your treatment (such as a car accident or fall), we may be obligated to provide information to legal counsel, insurance companies, and the like.
- Sometimes, we have computer issues and tech support may need to manipulate our computers. We always confine their activities to the software, and we use "dummy" patients when we have to run tests.
- If you force us to send you to a collection agency, we must provide them means to contact you and evidence of the treatment provided for which we are owed. So, please, just pay us in a timely fashion!!
- In the rare circumstances where you are referred to a specialist, obviously we will need to discuss your case. Similarly, if you are referred by a physician, for example, we have to discuss your case with them.

We will always notify you if there are any unusual circumstances that force us to share information that we normally hold protected.

I understand these policies as described above.

Signature_____

Informed Consent for General Dental Procedures

You, the patient, have the right whether or not to accept treatment recommended by your doctor. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.

Do not consent to treatment unless and until you discuss potential benefits, risks, and complications with your doctor and all of your questions are answered. By consenting to the treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

It is very important that you provide your doctor with accurate information before, during, and after treatment. It is equally important that you follow your doctor's advice and recommendations regarding medication, pre- and post- treatment instructions, referrals to other doctors or specialists, and return for scheduled appointments. If you fail to follow the advice of your doctor, you may increase the chance of a poor outcome.

Please read and initial the items below and sign at the bottom of the form.

1. Treatment to be Provided

I understand that during my course of treatment that the following care may be provided:
Examinations/Preventive Services ___ Restorations ___ Crowns/Bridges___ Other necessary procedures__

Patient Initials ____

2. Drugs and Medications

I understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction).

Patient Initials ____

3. Changes in Treatment Plan

I understand that during treatment it may be necessary to change, add, or remove procedures because of conditions discovered while working on the teeth that were not evident during examination; for example, root canal therapy following routine restorative procedures. I give my permission to the doctor to make any/all changes and additions as necessary. Patient Initials_____

4. I give permission to the dental office to bill my dental insurance provider for the treatment provided, if applicable. Patient Initials____

_____ _____
Patient Signature Date