CRANBERRY DENTAL STUDIO

Welcome to Cranberry Dental Studio

Patient Health History Form

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Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

Title: _____ **Gender:** ○ Male ○ Female **Family Status:** ○ Married ○ Single ○ Child ○ Other
Mr/Ms/Mrs/etc

Birth Date: _____ **SS#:** ___-__-____ **Prev. Visit:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Please enter Employer and Occupation

_____

_____

Special Interests/Hobbies:

_____

_____

Whom may we thank for referring you to our practice?

_____

In an emergency who should be notified? Please enter Name and Phone number below:

_____

_____

Primary Dental Insurance:

Name of Insured:

_____ _____ ____

Last First MI

Insured's Address: _____ _____

Address 1 Address 2

_____ _____ _____-____

City State Zip Code

Insured's Birth Date: _____ **Insured's Social Security Number: _____**

Insured's Employer Name: _____ **Insurance Company Phone Number: (_____) _____**

Patient's relationship to insured: ○ Self ○ Spouse ○ Child ○ Other

Insurance Plan Name: _____ **ID #: _____** **Group #: _____**

Secondary Dental Insurance

Name of Insured:

_____ _____ ____

Last First MI

Insured's Birth Date: _____ **Patient's relationship to insured:** ○ Self ○ Spouse ○ Child ○ Other

ID #: _____ **Group #: _____**

Insurance Plan Name: _____

Insurance Authorization:

☐ **By checking this box,**

I authorize my insurance company to pay the dentist all insurance benefits rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

DENTAL INFORMATION

How would you rate the condition of your mouth?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Previous Dentist Name:

_____

_____

Date of most recent dental exam and dental x-rays:

_____

_____

I routinely see my dentist every:

☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

What is the reason for your visit today?

_____

_____

Check all that apply:

☐ Had complications from past dental treatment
☐ Had any reactions to local anesthetic
☐ Have dry mouth
☐ Food gets trapped between any teeth
☐ Have popping and/or clicking of your jaw/TMJ
☐ Clench or grind your teeth
☐ Have tinnitus (ringing in ears)
☐ Snore or wake up frequently during the night
☐ Gums bleed when brushing or flossing
☐ Have or had gum recession
☐ Have or had a burning sensation in your mouth
☐ Would like to change the appearance of your smile
☐ Had trouble getting numb
☐ Had or have braces (orthodontic treatment)
☐ Teeth are sensitive to hot, cold, biting or sweets
☐ Have whitened your teeth
☐ Have difficulty chewing
☐ Get headaches or migraines
☐ Neck or upper back pain
☐ Wear or have worn a bite appliance
☐ Have been treated for gum disease
☐ Had an unpleasant taste or odor in your mouth
☐ Do you use tobacco products
☐ Have you had Botox or dermal filler treatments

If any of the checked boxes need further explanation, please describe:

_____

_____

_____

_____

Medical History

Indicate which of the following conditions you have or have had. By checking the box it will indicate a "YES" response, leaving blank will indicate a "NO" response.

- ☐ *Pre-Med - Amox
- ☐ Allergies- Seasonal
- ☐ Allergy - Latex
- ☐ Allergy - Sulfa
- ☐ Asthma
- ☐ Dizziness
- ☐ Fainting
- ☐ Heart Murmur
- ☐ HIV
- ☐ MitralValve Prolapse
- ☐ Psychiatric Disorder
- ☐ Sinus Problems
- ☐ Tuberculosis
- ☐ *Pre-Med - Clind
- ☐ Allergy - Aspirin
- ☐ Allergy - Metals
- ☐ Anemia
- ☐ Blood Disease
- ☐ Drug/Alcohol Use
- ☐ Glaucoma
- ☐ Heart Surgery
- ☐ HPV
- ☐ Osteoporosis/Bone Dx
- ☐ Radiation Treatment
- ☐ Stroke
- ☐ Ulcers
- ☐ *Pre-Med - Other
- ☐ Allergy - Codeine
- ☐ Allergy - Other
- ☐ Arthritis
- ☐ Cancer
- ☐ Epilepsy
- ☐ Head Injuries
- ☐ Hepatitis
- ☐ Kidney Disease
- ☐ Other
- ☐ Respiratory Problems
- ☐ Temporal Arteritis
- ☐ Acid Reflux
- ☐ Allergy - Erythro
- ☐ Allergy - Penicillin
- ☐ Artificial Joints
- ☐ Diabetes
- ☐ Excessive Bleeding
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Liver Disease
- ☐ Pacemaker
- ☐ Rheumatic Fever
- ☐ Thyroid Disease

If any conditions or alerts selected above need further clarification, please describe below:

Do you take antibiotic premedication for your dental visits? * ◯ Yes ◯ No

Please check all that apply:

- ☐ Ever been hospitalized (illness/injury)
- ☐ Tobacco/Alcohol Use
- ☐ FEMALE: Nursing
- ☐ Presently being treated for other illnesses
- ☐ FEMALE: Taking birth control pills
- ☐ Subject to frequent headaches
- ☐ FEMALE: Pregnant

If yes, please explain in the box provided below.

What is your estimate of your general health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Name of your physician and phone number:

_____

_____

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

_____

_____

Are you currently taking any anti-clotting medications such as Coumadin, Warfarin, or Aspirin? * ◯ Yes ◯ No

If yes, please list below:

_____

_____

List all medications (prescription and non-prescription

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

☐ *By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes.

Response Date: / /

Consent for Services and Financial Policy

As a 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 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 in cash at the time services are performed unless other arrangements are made.

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, unless otherwise indicated.

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

☐ * **By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the Administration Form.**

Consent for Internet Communications

I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use all reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf.

☐ * **I have read the information above regarding the secured uploading of patient information to the web site for the dental practice, and grant the dental practice permission to securely upload my patient information to the web site. This will serve as my electronic signature.**

Name of person filling out this form:

_____

_____

Relationship to patient: *

☐ Self ☐ Parent ☐ Step-parent ☐ Grandparent ☐ Legal Guardian ☐ Other

HIPAA Acknowledgement

I authorize this office to disclose or discuss my personal and/or dental information with the following person(s).

(Please enter name and relationship to patient.) _____

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

☐ * **By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the HIPAA Disclosure Form.**

Response Date: ____/____/_____