OFFICE USE ONLY

ID: _____

Chart ID: _____

FOX FAMILY DENTISTRY

Cosmetic • Laser • Implant • General

Dentistry

HEALTH HISTORY & REGISTRATION

DATE _____

PATIENT'S NAME Last _____ First _____ Middle Initial _____ Preferred Name _____

PATIENT IS: ☐ Policy Holder ☐ Responsible Party

PATIENT INFORMATION

Address 1 _____ Address 2 _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Sex: ☐ M ☐ F Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Soc. Sec. # _____ Driver's License # _____ Birthdate _____ Age _____

Email _____ ☐ I would like to receive correspondence via email

RESPONSIBLE PARTY INFORMATION (If someone other than patient)

First Name _____ Last Name _____ Middle Initial _____

Address 1 _____ Address 2 _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Soc. Sec. # _____ Birthdate _____ Driver's License # _____ Relation to Patient _____

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Employment Status ☐ Full Time ☐ Part Time ☐ Retired Student Status ☐ Full Time ☐ Part Time

Medicaid ID: Employer ID: Carrier ID:

Preferred Dentist: Preferred Pharmacy: Preferred Hygienist:

Whom may we thank for referring you to our practice?

☐ Friend/Family/Physician

_____

☐ Google ☐ Insurance ☐ Yelp

☐ Other _____

DENTAL INSURANCE INFORMATION (Primary Carrier)

Insured's Name _____

Insurance Co. _____ PHONE _____

Insurance Co. Address _____

Insured's Employer _____

Insurance Employer Address _____

Insured's Soc. Sec. # _____ Insured's Birthdate _____ Group # _____ Local # _____

Relationship to Insured

☐ Self ☐ Spouse ☐ Child ☐ Other

Rem. Benefits: _____ .00

Rem. Deduct: _____ .00

SECONDARY INSURANCE INFORMATION

Insured's Name _____

Insurance Co. _____ PHONE _____

Insurance Co. Address _____

Insured's Employer _____

Insurance Employer Address _____

Insured's Soc. Sec. # _____ Insured's Birthdate _____ Group # _____ Local # _____

Relationship to Insured

☐ Self ☐ Spouse ☐ Child ☐ Other

Rem. Benefits: _____ .00

Rem. Deduct: _____ .00

It is important that we know about your Medical and Dental History. These facts have a direct bearing on your Dental Health. This information is strictly confidential and will not be released to anyone. Thank you for taking the time to completely fill out this questionnaire.

Are you under a physician's care now? ☐ Yes ☐ No If yes _____

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No If yes _____

Hav eyou ever had a serious head or neck injury? ☐ Yes ☐ No If yes _____

Are you taking any medications, pills, or drugs? ☐ Yes ☐ No If yes _____

Do you take, or have you taken, Phen-Fen or Redux? ☐ Yes ☐ No If yes _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containting bisphosphnates? ☐ Yes ☐ No If yes _____

Are you on a special diet? ☐ Yes ☐ No

Do you use tobacco? ☐ Yes ☐ No

Do you use controlled substances? ☐ Yes ☐ No If yes _____

Women: Are you . . .

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Other_____

☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

WHAT MEDICATIONS ARE YOU CURRENTLY TAKING?

PLEASE ✓ YES OR NO OF THE FOLLOWING WHICH YOU HAVE HAD OR PRESENTLY HAVE:

	Yes	No		Yes	No		Yes	No		Yes	No
AIDS/HIV Pos.	☐	☐	Cortisone treatments	☐	☐	Hemophilia	☐	☐	Radiation Treatments	☐	☐
Alzheimer's Disease	☐	☐	Diabetes	☐	☐	Hepatitis A	☐	☐	Recent Weight Loss	☐	☐
Anaphylaxis	☐	☐	Drug Addiction	☐	☐	Hepatitis B or C	☐	☐	Renal Dialysis	☐	☐
Anemia	☐	☐	Easily Winded	☐	☐	Herpes	☐	☐	Rheumatic Fever	☐	☐
Angina	☐	☐	Emphysema	☐	☐	High Blood Pressure	☐	☐	Rheumatism	☐	☐
Arthritis / Gout	☐	☐	Epilepsy or Seizures	☐	☐	High Cholesterol	☐	☐	Scarlet Fever	☐	☐
Artificial Heart Valves	☐	☐	Excessive Bleeding	☐	☐	Hives or Rash	☐	☐	Shingles	☐	☐
Artificial joints	☐	☐	Excessive Thirst	☐	☐	Hypoglycemia	☐	☐	Sickle Cell Disease	☐	☐
Asthma	☐	☐	Fainting Spells / Dizziness	☐	☐	Irregular Heartbeat	☐	☐	Sinus Trouble	☐	☐
Blood Disease	☐	☐	Frequent Cough	☐	☐	Kidney Problems	☐	☐	Spina Bifida	☐	☐
Blood Transfusion	☐	☐	Frequent Diarrhea	☐	☐	Leukemia	☐	☐	Stomach / Intestinal Disease	☐	☐
Breathing Problems	☐	☐	Frequent Headaches	☐	☐	Liver Disease	☐	☐	Stroke	☐	☐
Bruise Easily	☐	☐	Genital Herpes	☐	☐	Low Blood Pressure	☐	☐	Swelling of Limbs	☐	☐
Cancer	☐	☐	Glaucoma	☐	☐	Lung Disease	☐	☐	Thyroid Disease	☐	☐
Chemotherapy	☐	☐	Hay Fever	☐	☐	Mitral Valve Prolapse	☐	☐	Tonsillitis	☐	☐
Chest Pains	☐	☐	Heart Attack / Failure	☐	☐	Osteoporosis	☐	☐	Tuberculosis	☐	☐
Cold Sores / Fever Blisters	☐	☐	Heart Murmur	☐	☐	Pain in Jaw Joints	☐	☐	Tumors or Growths	☐	☐
Congenital Heart Disorder	☐	☐	Heart Pacemaker	☐	☐	Parathyroid Disease	☐	☐	Ulcers	☐	☐
Convulsions	☐	☐	Heart Trouble / Disease	☐	☐	Psychiatric Care	☐	☐	Venereal Disease	☐	☐
									Yellow Jaundice	☐	☐

Have you ever had any serious illness not listed above? ☐ Yes ☐ No If yes _____

Comments

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I , or my minor child, ever have a change in health. I certify that I and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Signature of Patient, Parent, or Guardian: _____ Date: _____

DENTAL HISTORY

What is the reason for your visit today?

☐ Cleaning and Exam ☐ Broken Tooth ☐ Toothache ☐ 2nd Opinion ☐ Other

How long ago was your last dental visit?

☐ Less than 6 months ☐ 6 months to 1 year ☐ 1-2 years ☐ Over 2 years

How long ago was your last dental cleaning?

☐ Less than 6 months ☐ 6 months to 1 year ☐ 1-2 years ☐ Over 2 years

How long ago was your last set of full mouth X-rays (typically 18 films)?

☐ Less than 3 years ☐ 3 - 5 years ☐ Over 5 years

How long ago was your last set of bitewing X-rays (typically 4 films)?

☐ Less than 6 months ☐ 6 months to 1 year ☐ 1-2 years ☐ Over 2 years

How long ago was your last panoramic X-ray?

☐ Less than 6 months ☐ 6 months to 1 year ☐ 1-2 years ☐ Over 2 years

What was done at your last dental visit?

☐ Cleaning and Exam ☐ Fillings ☐ Root Canal ☐ Crowns/Bridges ☐ Extractions ☐ Periodontal Treatment ☐ Implant Placement

Are any of your teeth sensitive to:

☐ Hot? ☐ Cold? ☐ Sweets? ☐ Biting or Chewing? ☐ Other

How often do you brush?

☐ 2x or more daily ☐ 1x daily ☐ Less than 1x daily

How often do you floss?

☐ Daily ☐ Weekly ☐ Rarely

What type of toothpaste do you use?

☐ Flouridated ☐ Whitening ☐ Natural/Herbal ☐ Other

Do your gums hurt or bleed?

☐ Yes ☐ No

Does food tend to get caught in between your teeth?

☐ Yes ☐ No

Have you ever had periodontal treatment (deep cleaning/gum graft)?

☐ Yes ☐ No

If "Yes", how long ago did you receive treatment?

☐ Less than 6 months ☐ 6 months to 1 year ☐ 1-2 years ☐ Over 2 years

Are you satisfied with the appearance of your teeth?

☐ Yes ☐ No

If "No", what would you like to see improved?

☐ Shape ☐ Color ☐ Spacing ☐ All of these ☐ Other

Do you feel nervous about having dental treatment?

☐ Yes ☐ No

Have you ever had an upsetting dental experience?

☐ Yes ☐ No

Have you ever had any adverse reactions to dental work, anesthesia, or nitrous oxide?

☐ Yes ☐ No

Are you deeply concerned about the finances required to return your mouth to excellent dental health?

☐ Yes ☐ No

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

Consent For Treatment

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) _____'s dental needs.
   Patient's Name

2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for complete recital of any possible complications.

4. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made.

5. In the event my account becomes delinquent, I understand that I am responsible to pay actual court costs and attorney's fees that may be added to my account.

6. We require two (2) business days notice of cancellation of any appointment. There will be a $50 fee for any broken appointments.

Patient Signature _____ Date _____
(Must be signed by responsible party)