Health History Form

ADA American Dental Association®
America's leading advocate for oral health

Email: 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

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

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 *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?	☐	☐	☐
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? (*Check 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:

	Yes	No	DK
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?

	Yes	No	DK
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 dietary 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?	☐	☐	☐
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 an antiresorptive agent (like Fosamax®, Actonel®, Atelvia, Boniva®, Reclast, Prolia) for osteoporosis or Paget's disease?	☐	☐	☐
Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia®, Zometa®, XGEVA) 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 i n 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:
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
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	DK
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	DK
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	DK
Glaucoma	☐	☐	☐
Hepatitis, jaundice or liver disease	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Neurological disorders If yes, specify: _____	☐	☐	☐
Sleep disorder	☐	☐	☐
Do you snore?	☐	☐	☐
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	☐	☐	☐

	Yes	No	DK
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	☐	☐	☐

Name of physician or dentist making recommendation:

Phone: *Include area code*
( )

	Yes	No	DK
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:

Signature of Dentist: Date:

FOR COMPLETION BY DENTIST

Comments:

Carolina Fellows Family Dentistry
A Granville Vance Public Health Facility

General Consent for Dental Treatment

I authorize dental treatment including necessary or advisable examination, radiographs (x-rays), diagnostic aids or local anesthesia.

In general terms, dental treatment may include but is not limited to one or a number of the following:

- Administration of local anesthesia.
- Cleaning of the teeth and application of topical fluoride.
- Scaling and root planning with local anesthesia.
- Application of sealants to the grooves of the teeth.
- Treatment of diseased or injured teeth with dental restorations.
- The replacement of missing teeth with a dental prosthesis (crown, partials, etc.)
- Treatment of diseased or injured oral tissues (hard and/or soft).
- Treatment of malposed (crooked) teeth and/or developmental abnormalities.
- Treatment of the canal or pulp chamber that lies in the middle of the tooth and its root also known as “endodontic” therapy or root canal

Risk of Dental Procedures in General

Included (but not limited to) are complications resulting from the use of dental instruments, drugs, medicines, analgesics (pain killers), anesthetics and injections. These complications include pain, infection, swelling, bleeding, sensitivity, numbness and tingling sensations in the lip, tongue, chin, gums, cheeks and teeth. Thrombophlebitis (inflammation to a vein), reaction to injections, change in occlusion (biting), muscle cramps and spasms. Tempromandibular jaw (TMJ) joint difficulty, loosening of teeth or restoration in teeth, injury to other tissues. Referred pain to the ear, neck and head, nausea, allergic reactions, itching, bruises, delayed healing, sinus complications and further surgery. Medication and drugs may cause drowsiness and lack of awareness and coordination (which can be influenced by the use of alcohol or other drugs), thus it is advisable not to operate any vehicle or hazardous device, or work for twenty-four hours or until recovered from their effects. I understand the effects of local anesthetics on oral soft tissues sometimes last long after the appointment is over, and care must be taken to avoid chewing and biting the area that’s numb causing injury to lips, cheek, and tongue, until numbness is completely gone.

Changes in Treatment Plan

I understand that during treatment, it may be necessary to change and/or add procedures because of conditions found while working on the teeth that were not discovered during examination. Upon my consent, I will give my permission to the dentist to make any/all changes and additions as necessary.

Fillings

I understand that I may experience hot and cold sensitivity, pain or discomfort following routine restorative procedures and that this is usually temporary and should settle without further treatment. If in the event that my condition does not get any better, I understand that I may need further dental treatment, the most common being root canal therapy, resulting in additional costs.

Crowns (Caps), Bridges and Onlays

I understand that sometimes it is not possible to match the color of artificial teeth with natural teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realized the final opportunity to make changes in my new crown or bridge (including shape, fit, size and color) will be before cementation. Once cemented, I understand that any changes in shape, fit, size or color will incur an additional charge.

Alternative Treatment

I understand that I have the right to choose, on the basis of adequate information, from alternate treatment plans that meet professional standards of care.

By signing below, I consent to the general treatments and/or proposed treatment.

Patient/Guardian (Printed): _____

Patient/Guardian (Signature): _____

Date: _____

Medical Release and Assignment of Benefits

Patient Name:

_____ _____
Last *First* *MI*

Date of Birth: _____/_____/_____

I give permission for Carolina Fellows Family Dentistry (CFFD) to check income and insurance coverage through employers and/or other sources as necessary to determine my eligibility for services.

I give permission for CFFD to release any medical information (including, but not limited to, information regarding chemical dependency problems and/or treatment, HIV results, drug screen results and assessment), which is requested by Medicare, Medicaid, other insurance companies, or other agencies assisting in my care.

I authorize the CFFD and the applicable County Department of Social Services (e.g., Granville, Vance, etc.) to discuss information about me in the event I apply for financial assistance, including Medicaid. This information may include the following: date of application, application status, and the reason my application remains pending, any verification required to complete my application, the date and reason if denial (if applicable).

I understand that Medicare will only pay for services that are "reasonable and necessary for medical treatment and diagnosis" under section 1862 (a) (1) of the Medicare Law. I am personally responsible for any part of my bill not covered by Medicare, Medicaid or other insurance.

I understand that I may receive services or be referred for services provided by other physicians, laboratories, hospitals, or other agencies. I understand fees that other agencies charge are my personal responsibility. I also understand that fees are based on income at CFFD, this adjustment does not apply to fees of persons or entities outside of the CFFD.

I request that Medicaid, Medicare, or other insurance payment for services that I receive through CFFD (including physician services) are to be paid directly to CFFD. I agree to pay to CFFD any money that I receive from any source that is sent directly to me as payment for services that I have received from CFFD. I will make this payment within 30 days of the day that I receive this money.

I understand that this consent will remain in effect while I am receiving care at CFFD and/or until all unpaid accounts with CFFD are settled. I also understand that I may cancel this consent in writing delivered to CFFD anytime during CFFD's normal business hours.

Dental Clinic Financial Policy Information

Thank you for choosing Carolina Fellows Family Dentistry (CFFD). As a patient you should understand our fees, bills you are responsible for, and other financial policies as it applies to your dental care. We accept patients who have Medicaid, Health Choice, some private dental insurances and patients who are uninsured.

You are expected to pay your bill at the time of your visit. You may ask our patient representative to apply for our sliding fee scale payment plan that ***may*** qualify you to receive services at a reduced rate.

In the event we failed to bill for a procedure that was performed, we will bill you or your third party payor.

If you have Medicaid, Health Choice, private dental insurance, or other responsible agency (i.e. Maria Parham Hospital Cancer Center, County detention centers, etc) we will bill them for your treatment. If you have an insurance co-payment, the co-pay is due at the time of your visit. Medicaid and Health Choice do not pay for every procedure you may need. You will be expected to pay for the treatment that is not covered by Medicaid and Health Choice and any charges that are not covered by your private insurance plan. However, **you** must pay your balance if your insurance does not pay us in 90 days. If you have questions or concerns with what your insurance plan covers or pays, please talk with your insurance company.

I understand that if outstanding balances remain unpaid, the CFFD has the right unless restricted by State or Federal regulations; to refuse or deny further services to you; submit your outstanding debt to the North Carolina Debt Setoff Collection Clearinghouse, pursuant to which qualifying debts may be automatically deducted from any State tax refund or lottery winnings you may be owed; and/or refer your account to a collection agency.

(Please initial each line below to demonstrate that you understand our financial policies)

_____ I will notify CFFD of any changes in my income for Program services _____ I understand I am responsible for all charges _____ I agree for my insurance to pay CFFD for dental care _____ I agree for CFFD to give dental information to my insurance company if applicable. _____ I have read the above information and have been able to ask questions. _____ I have received answers to my questions and agree to comply.	**INSURANCE/MEDICAID/HEALTH CHOICE** • Tell us if you have insurance now or when you start getting insurance coverage. • If you have Medicaid and other insurance, Medicaid will pay ***after*** your other insurance pays. • ***If you do not tell us about other insurances, Medicaid will not pay.** • **You** must pay your bill if we are not a provider for your insurance plan. • You **must** show a current Medicaid, Health Choice or private insurance card at each visit. • If you do not have proof of current coverage you may be asked to pay the charges for the visit. • Clients bringing in their Medicaid and/or insurance card after date of service must do so within a time frame that payors allow for billing of the service.

X_____ _____/_____/_____
Signature of patient, parent or legal guardian Date

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