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 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?	☐	☐	☐
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 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	☐	☐	☐

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*
( )

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:

SPARTA FAMILY DENTISTRY

Alan Domeyer, DDS Julie Domeyer, DDS

Welcome! Thank you for selecting Sparta Family Dentistry! To help us meet all your dental health care needs, please fill out this form completely. If you have any questions or need assistance, please ask us. We are happy to help!

Name:_____ Date of birth: __/__/__ Sex: M F

Address_____City, State, Zip _____

Home phone _____Work phone _____Cell _____

Email_____ SSN#_____

Referred to our office by_____

Responsible Party (Guardian) Information

Name of Guardian_____ SSN#_____

Address (If different than patient)_____City, State,Zip_____

Occupation_____ Employer_____

Employer's Address_____Phone_____

Dental Insurance Information

Insurance Company_____Insured Name_____

Insure DOB___/__/__ Relationship to patient_____

Subscriber #_____Group #_____Employer_____

Secondary Dental Insurance

Insurance Company_____Insured Name_____

Insure DOB___/__/__ Relationship to patient_____

Subscriber #_____Group #_____Employer_____

Emergency Contact

Name_____Relationship to you_____

Address_____Phone_____

SPARTA FAMILY DENTISTRY

Consent for Treatment

I certify that I have read and understand the above information to the best of my knowledge. All questions have been accurately answered. I understand that providing incorrect information on the health history form can be dangerous to my health. I hereby authorize Sparta Family Dentistry to administer and perform the necessary procedures, such as x-rays, anesthetics and dental treatment deemed necessary or advisable with the diagnosis of my dental condition. I understand there are certain risks inherent in the dental treatment including pulpal sensitivity or damage, tissue swelling or bruising, soreness of jaws and paresthesia. This list is not all inclusive and there are other procedurally specific risks that your dentist will advise you on.

Insurance Release: I authorize release of information regarding my dental treatment to my insurance carrier. I agree to be responsible for payment of services rendered during my ineligible insurance period and any balance not paid by the insurance carrier. I understand that insurances are billed as a courtesy and that I am ultimately responsible for all cost of treatment.

Children or Minors:

Because (name of child)_____is a minor, it is necessary that signed permission be obtained from a parent or guardian before any dental services are rendered. Such authorization is hereby granted. I agree to be responsible for any bills incurred on behalf of this child during their dental treatment.

Signature:_____Date__/__/__

SPARTA FAMILY DENTISTRY

Office Financial Policy

Thank you for choosing our office. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of this mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options. Payment is expected at the time of service.

Payment Options:

-Cash or Check

-For patients without dental insurance we offer a 5% courtesy accounting adjustment when fees are paid in full on the day of service (or in advance) by cash or check.

-Credit Card - Mastercard or Visa.

-Care Credit

-Care Credit allows you to pay with monthly payment plans. If you are interested in learning more about this option please discuss with the Front Desk.

Please Note:

Our office requires payment in full the day of your appointment for all treatment plans of less than $500. For cases involving a lab (ex: Dentures, crowns, space maintainers, etc) half is due the day of the first appointment and the second half is due on the day of completion. If you choose to pay in two portions you are not eligible for the 5% discount.

For larger, more comprehensive or complex treatment plans arrangements may be made on a case by case basis. Any payment plan must be decided upon prior to the day your treatment is set to begin.

For patients with dental insurance we are happy to work with your carrier to maximize your dental benefit and directly bill them for reimbursement for your treatment. However, if we do not receive payment from your insurance carrier within 45 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier. You are responsible for paying your portion (co-pay) on the day of service.

Our office charges up to $50 for returned checks.

If you have any questions please do not hesitate to ask.

Patient, Parent or Guardian Signature _____ Date ___/___/_____

Patient Name (please print) _____

SPARTA FAMILY DENTISTRY

Julie Domeyer, DDS
Alan Domeyer, DDS

Release of Information/Financial Responsibility/Authorization for Payment

I (name of patient)_____and/or (name of insured)_____ hereby authorize Sparta Family Dentistry to affix my name to any and all claims or documents as related to any and all health benefits due to me and my dependents through my employment with (name employer) _____I hereby authorize payment of dental benefits otherwise payable to me directly to the office above. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to the claim.

Signature of Patient (parent or guardian if a minor)_____

Signature of Insured_____Date__/__/__

Notice of Privacy Practices (HIPAA)

A copy of our office Notice of Privacy Practices (HIPAA) is available in our office. You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activites and healthcare operations. It also describes the uses and disclosures we may make of your protected health information and of other important matters about your protected health information. We encourage you to read it carefully and completely before signing this consent. Upon your request, we will be happy to provide you with your own personal copy of our Privacy Practices.

May we phone you to confirm appointments?	Yes	No
May we leave a message on your answering machine at home or on your cell phone?	Yes	No
May we schedule appointments with person(s) listed below	Yes	No
May we discuss your dental condition with any member of your family?	Yes	No

If YES, Please name the member allowed:

Name_____ Relationship_____ Phone_____

Name_____ Relationship_____ Phone_____

Name_____ Relationship_____Phone_____

Signature_____Date___/___/___