Health History Form

E-mail: Today's Date:

ADA
American Dental Association
www.ada.org

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 codes
Cell Phone: ( )
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?	☐	☐	☐
Are you in good health?	☐	☐	☐
Has there been any change in your general health within the past year?	☐	☐	☐
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐	☐
Are you taking or have you recently taken any prescription or over the counter medicine(s)?	☐	☐	☐

Physician Name: Phone: Include area code ( )
Address/City/State/Zip:
If yes, what condition is being treated?
Date of last physical exam:
If yes, what was the illness or problem?
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?	☐	☐	☐
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 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:

	Yes	No	DK
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	☐	☐	☐

	Yes	No	DK
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	☐	☐	☐
Glaucoma	☐	☐	☐

	Yes	No	DK
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: _____

COTTONWOOD DENTAL

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name_____ Phone#_____

Address_____

Email_____ Social Security#_____

SECTION B: TO THE PATIENT-PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY:

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: 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 activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this consent. We encourage you to read it carefully and completely before signing this consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, any time by contacting:

Contact Person: Office Manager Telephone: 972-261-1166 Fax: 972-692-7030

Address: 2230 W. Walnut Hill Lane, Irving, TX 75038

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the contact person listed above. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

I, _____, have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that, by signing this consent form, I am giving consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations.

Signature_____ Date_____

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name_____ Relationship to Patient_____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT. This consent will be filed in the patient's chart.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

I, _____, have been given the opportunity to request a copy of this office's Notice of Privacy Practices.

_____

Print Name

_____

Signature Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

Individual refused to sign Communication barriers prohibited obtaining the acknowledgement

An emergency situation prevented us from obtaining acknowledgement Other (please specify)_____

Conditions of Treatment, Payments and Deposit Policy

As a condition of your treatment by Cottonwood Dental, financial arrangements must be made in advance. Financial responsibility on the part of each patient must be determined before treatment, including any insurance benefits. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid at the time services are rendered.

Cottonwood Dental will help prepare the patient's insurance claim, assist in making collections from insurance companies and will credit all collections to the patient's account. The "patient portion" on our treatment plans is only an estimate of what your insurance may pay. Cottonwood Dental does not render services on the assumption that our charges will be paid in full by an insurance company. In the event your insurance company pays less than their estimated amount, you are responsible for the unpaid portion and will be billed. If correct insurance information is not provided and the claim(s) are denied for any reason, the patient will then be responsible for any unpaid amounts and will be billed accordingly.

In the interest of your good health and the aesthetics of your dental work, our dentist prefers to use composite (tooth colored) fillings and porcelain paced (tooth colored) crowns on all teeth. You are being informed that many, but not all, insurance plans only allow the benefit of amalgam (silver/mercury) fillings and the benefit of full cast (metal/gold) crowns on posterior (back) teeth—this practice is called "downgrading." You will be responsible for the amount that your insurance does not cover. If you prefer amalgam fillings and/or full cast metal crowns on your posterior teeth, please advise the dentist when the diagnosis is made for your treatment plan.

When we schedule longer appointments for your treatment, we will request a deposit be made to reserve the time for you. This deposit will be applied to your cost of treatment. Deposits may be forfeited if you do not give us at least 2 (two) business days notice to change your appointment.

All oral sedation cases must pay in full for treatment at pre-op appointment because we cannot collect money nor have consents signed while a patient is under sedation.

In consideration for the professional services rendered to me, or at my request, I agree to pay the stated value of services to Cottonwood Dental, or its assignee, at the time services are rendered, or as written financial agreements should be extended. I further agree that the stated value of said services shall be as billed unless objected to, by me, in writing, within the time for payment. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit were instituted. I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read and agree to the above conditions of treatment, payments and deposits.

Signature of guarantor of payment/responsible party_____

Date_____/_____/_____ Relationship to Patient_____

Cottonwood Dental
2230 W. Walnut Hill Lane
Irving, Texas 75038

Cancellation Policy/No Show Policy

As a courtesy to our patients in keeping appointments, our protocol is to give a reminder via telephone 48 business hours prior to scheduled appointment (call placed to telephone number(s) on record) and/or provision of appointment cards. Please note, it is the patient's and/or guardian's responsibility for ensuring the patient appointment is kept.

- *Cancellation/No Show Policy for Doctor Appointment*

  We understand that there are times when you must miss an appointment due to an emergency or obligation for work or family. We truly enjoy serving you as we value all of our patients. However, when you do not call to cancel an appointment, you may be preventing another valued patient from getting much needed treatment. Alternatively, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" schedule.

  If an appointment is not cancelled at least 24-48 business hours in advance you will be charged a forty dollar ($40) fee; this will not be covered by your insurance company. If our staff is successful in filling your appointment time with another patient, there will be no broken appointment charge. Please note, however, this is *not* a guarantee.

- *Scheduled Appointments*

  We understand delays can happen, however we strive to respect all of our patient's and doctor's valuable time.

  If a patient is late to their scheduled appointment by more than 10 minutes, we may have to reschedule the appointment. If you are running late, please give us a courtesy call to let us know you are still coming.

Please sign below to acknowledge and agree to the cancellation policy.

Print Patient Name	**Patient/Guardian Signature**	**Date** / /
Print Witness Name	**Witness Signature**	**Date** / /

Thank you for understanding! We value our patients!