

TriState Family Dental Centers

HEALTH HISTORY

Patient Name: _____

Acct. #: _____

Do you have or have you ever had any of the following?	Please fill in the blank or answer yes (Y) or no (N) to each of the following questions.	Are you allergic to any of the following?
Please circle yes (Y) or no (N) for each.	Are you currently under a doctor's care?..... Y N	Please circle yes (Y) or no (N) for each.
Heart Trouble/Disease Y N	Explain: _____	
Angina (Chest pain) Y N	_____	Local Anesthetic Y N
Artificial heart valve Y N	Have you had any other serious illness not listed? Y N	Penicillin Y N
Heart Murmur Y N	Explain: _____	Aspirin Y N
Cardiac Pacemaker Y N	_____	Novocaine Y N
Mitral Valve Prolapse Y N	Have you been hospitalized in the last two years?..... Y N	Sulfa Y N
Rheumatic Fever Y N	Explain: _____	Codeine Y N
Artificial Joint Y N	_____	Metal Y N
When: _____	Are you on a special diet? Y N	Latex Rubber Y N
Arthritis Y N	Do you smoke/chew tobacco? Y N	Acrylic Y N
Stroke Y N	How long? _____	Costume Jewelry Y N
High Blood Pressure Y N	Have you ever been told to take antibiotics before a dental appointment? Y N	Please list any other allergies you may have that are not listed above.
Venereal Disease Y N	Are you currently taking a blood thinner? ... Y N	_____
Hepatitis A Y N	Are you currently taking or have you ever taken Bisphosphonates for osteoporosis, multiple myeloma or other cancers (Fosamax, Actonel, Boniva, Aredia, Zometa)? Y N	_____
Hepatitis B or C Y N	Have you ever had any problems associated with any previous dental treatment? Y N	_____
Epilepsy or seizures Y N	Explain: _____	Please list the name of your primary physician.
Diabetes Y N	_____	_____
Blood Disorder Y N	How long has it been since your last dental visit? _____	_____
Alcoholism Y N	Do you take any medications on a regular basis? Y N	Women Only
Drug Addiction Y N	Please list medications below: _____	Please indicate yes (Y) or no (N) for the following.
Tattoo/Body piercing Y N	_____	Pregnant Y N
Cancer Y N	_____	Trying to get pregnant Y N
Radiation Therapy to the neck or head .. Y N	_____	Nursing Y N
When: _____	_____	Taking birth control Y N
Chemotherapy Y N	_____	_____
Emphysema Y N	_____	_____
COPD Y N	_____	_____
Asthma Y N	_____	_____
Tuberculosis Y N	_____	_____
Sinus or nasal problems Y N	_____	_____
Stomach, Liver or Kidney Disease Y N	_____	_____
Autoimmune Disease Y N	_____	_____
Eating Disorder Y N	_____	_____
Frequent or recurring mouth sores Y N	_____	_____
Clicking, popping or pain in jaw joint ... Y N	_____	_____
Grinding or clenching teeth Y N	_____	_____

CONSENT TO TREATMENT

Dental procedures are usually successful. Occasionally, a procedure will not produce the desired result and will necessitate additional or different therapy. We make every effort to provide quality care, however, no assurance is given or implied that the results will be curative and/or successful to complete satisfaction. Due to individual patient differences there exists a risk of failure, relapse, selective retreatment or worsening of any present condition despite the care provided. All dental procedures have some inherent risks. These risks include, but are not limited to the following:

1. Allergic reaction to any of the drugs or materials used.
2. Pain or discomfort after the procedure is complete.
3. The continuation of numbness after local anesthetic.
4. Bleeding following surgical procedures.
5. Temporary or permanent soreness of the jaw joint.
6. Changes in the occlusion (bite).

Most dental procedures are elective and the patient may choose to have all, only a portion or none of the suggested treatment. Many times alternate procedures may be chosen. I authorize TriState Family Dental Centers to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. I authorize TriState Family Dental Centers to transmit my dental records electronically. If another party receives them in error, I absolve TriState Family Dental Centers of any and all liability relating to submission of said records. I am legally responsible for myself or the patient named on this form. I have read and understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided. I have received a copy of TriState Family Dental Centers' notice of privacy practices.

Signature: _____

Date: _____

Doctor's Initials: _____

Account # : _____ Date: _____ Scanned By: _____

TriState Family Dental Centers - Patient Registration

Patient Name: _____
Date of Birth: _____
Please circle: Male Female
Please circle: Married Single Minor Other
Address: _____
City, State, Zip: _____
Home Phone: _____ Cell: _____
May we call you at work? Yes No
Work Phone: _____ Ext. _____
Email: _____
Social Security #: _____
Employer: _____
Employer Address: _____
How did you hear about our office? Please check below.
____ Phonebook ____ Employer
____ Website ____ Location
____ Radio ____ Physician
____ Newspaper ____ Patient: _____
Emergency Contact: _____
Phone #: _____ Relationship: _____

Please fill out the following information for the spouse or legal guardian/both parents if the patient is a minor.

Name: _____
Date of Birth: _____
Address: _____
City, State, Zip: _____
Home Phone: _____ Cell: _____
Work Phone: _____ Ext: _____
SS# : _____
Employer: _____
Employer Address: _____

Name: _____
Date of Birth: _____
Address: _____
City, State, Zip: _____
Home Phone: _____ Cell: _____
Work Phone: _____ Ext: _____
SS# : _____
Employer: _____
Employer Address: _____

Dental Insurance Information

Primary Dental Insurance

Name of Insurance: _____
Insurance Address: _____
City, State, Zip: _____
Insurance Phone #: _____

Name of person who carries the insurance (Insured): _____

Insured Birthdate: _____
Insured SS#: _____
ID#: _____ Plan #: _____
Group #: _____

Secondary Dental Insurance

Name of Insurance: _____
Insurance Address: _____
City, State, Zip: _____
Insurance Phone #: _____

Name of person who carries the insurance (Insured): _____

Insured Birthdate: _____
Insured SS#: _____
ID#: _____ Plan #: _____
Group #: _____

Financial Responsibility Agreement and Assignment of Insurance Benefits

I hereby authorize my signature on all insurance claim forms at the offices of TriState Family Dental Centers for payment directly to them for services rendered. I authorize TriState Family Dental Centers to make and send copies of dental records that may be needed to file my insurance claims. I understand that I am responsible for charges incurred regardless of whether or not my insurance pays. I understand that office policy requires payment in full or the estimated portion not covered by insurance at the time of service unless other arrangements have been made with the credit manager. Past due balances are subject to a 1.5% per month (18% APR) service charge. I understand and agree that if any unpaid balance is assigned to a third party collection agency for collection or placed with an attorney to obtain judgment or otherwise satisfy payment of my account, a collection fee of 33.33% will be added to my account. I further agree to pay reasonable attorney fees and court costs. I understand and agree to the above terms.

Signature: _____

Date: _____

Is there anyone else we may speak with regarding your financial information and/or your treatment and medical history?

Spouses, other family members and/or friends must be listed below if you would like us to speak with them regarding your information.

Name: _____
Relationship: _____
Information to be released (Please check one or both below):
____ Financial/Account Information
____ Treatment/Medical History Information

Name: _____
Relationship: _____
Information to be released (Please check one or both below):
____ Financial/Account Information
____ Treatment/Medical History Information

I authorize TriState Family Dental Centers to release the information indicated above. This authority shall remain in effect until otherwise notified in writing.

Signature: _____

Date: _____