



Patient Health History & Information

Name _____ Preferred name _____ Date _____
First Middle Init. Last

Address _____ City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____ ext. _____

Cell Phone _____ Birth date _____ Social Security _____

Email Address _____ Circle: Child Single Married Divorced Widowed Gender: M / F

Employer _____ Employer Address _____ Position _____
City State

Referred by? (circle one) Website, Edmond Phone Book SWBYP Ins Co Location Patient _____ other _____

Emerg. contact _____ Relationship _____ Ph. _____

Spouse's Name _____ Birthdate _____ Social Security _____

Spouse's Employer _____ Spouse's Work Phone _____ Spouse's Cell _____

Who is the person responsible for this account? _____ Relationship to patient _____

DENTAL INSURANCE INFO

Name of Insured _____ Birth date _____ Social Security _____

Employer _____ Insurance Co. _____ Phone _____

MEDICAL HISTORY

Physician's Name _____ Phone _____

Have you had any recent serious illnesses or operations? _____

Have you ever had a blood transfusion? Yes or No If yes, please give approximate dates _____

Have you ever been told you need to pre-medicate prior to dental appointments due to a medical condition? Yes or No

Women: Are you pregnant? Yes or No Due Date: _____ Are you nursing? Yes or No

Are you taking Birth Control Pills? Yes or No Are you planning on becoming pregnant? Yes or No

Please check if you have or have had any of the following:

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Alcohol/Drug Abuse | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Latex Allergy | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Amoxicillin Allergy | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Sulfa Allergy |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Erythromycin Allergy | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Swelling of Feet/Ankles |
| <input type="checkbox"/> Anesthetic Allergy | <input type="checkbox"/> Fever Blisters | <input type="checkbox"/> Mouth Sores | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tobacco Habit |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Penicillin Allergy | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Valve Replacement | <input type="checkbox"/> Prolonged Bleeding | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Hearing Disorder | <input type="checkbox"/> Psychiatric Problems | |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Respiratory Disease | |
| <input type="checkbox"/> Cancer _____ | (please circle A - B - C) | <input type="checkbox"/> Rheumatic Fever | Other Conditions: |
| <input type="checkbox"/> Chemotherapy/Radiation | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Scarlet Fever | _____ |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> HIV Positive/ AIDS | <input type="checkbox"/> STD _____ | _____ |
| <input type="checkbox"/> Codeine Allergy | <input type="checkbox"/> Joint/Hip Replacement | <input type="checkbox"/> Shortness of Breath | _____ |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Kidney/Liver Disease | <input type="checkbox"/> Sleep Apnea | _____ |

Please list all prescribed and over the counter medications you are currently taking with the correlating diagnosis:

Herbal Supplements:

Medication Allergies:

DENTAL HISTORY

Previous Dentist Name and Address _____

When was your last visit to the dentist? _____ When was your last full mouth x-rays taken? _____

How would you rate your smile? Needs Improvement or Excellent

If you had a magic wand what would you change about your smile?

What, if any, would keep you from having dental treatment completed: Fear / Finances / Pain / Time
Circle all that apply

Have you ever had any serious trouble associated with previous dentistry? _____

Have you ever been diagnosed or treated for periodontal disease? (gum disease, pyorrhea, trench mouth) _____

Does dental treatment make you nervous? No _____ Slightly _____ Moderately _____ Extremely _____

How often do you brush your teeth? _____ Floss? _____ Toothbrush is: Soft / Medium / Hard / Electric

Please check if you have or have had any of the following:

- | | | |
|--|--|--|
| <input type="checkbox"/> Bleeding/Sore Gums | <input type="checkbox"/> Clenching/Grinding Teeth | <input type="checkbox"/> Sensitivity to Heat |
| <input type="checkbox"/> Unpleasant Taste/Bad Breath | <input type="checkbox"/> Loose Teeth or Broken Fillings | <input type="checkbox"/> Sensitivity to Sweets |
| <input type="checkbox"/> Clicking or Popping Jaw | <input type="checkbox"/> Sensitivity when Biting | <input type="checkbox"/> Sensitivity to Cold |
| <input type="checkbox"/> Food Collection between Teeth | <input type="checkbox"/> Sores or Growths in your Mouth | <input type="checkbox"/> Orthodontics |
| <input type="checkbox"/> Biting Cheeks/Lips | <input type="checkbox"/> Frequent Blisters on lips/mouth | <input type="checkbox"/> Difficulty opening or closing jaw |
| <input type="checkbox"/> Snoring | <input type="checkbox"/> Mouth Piercing | <input type="checkbox"/> Pain in your jaw joint or your face/ear |
| <input type="checkbox"/> Stained Teeth | <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Chipped or Broken Teeth |
| <input type="checkbox"/> Missing Teeth | <input type="checkbox"/> Achy Pain in Teeth | <input type="checkbox"/> Throbbing Pain |
| <input type="checkbox"/> Partial Dentures | <input type="checkbox"/> Complete Dentures | <input type="checkbox"/> Dental Implants |

AUTHORIZATION AND RELEASE

In accordance with the Privacy Rules of HIPAA and with my understanding of the Patient Notice that I have read, I am hereby giving my full consent to Santa Fe Dental to maintain my medical records, transmit, forward and or release information about me, my health information and/or my Personal Health Information to any applicable person(s) or agencies, provided it is in my best interest and/or for the advancement or continuance of any health care services which I am being treated. I have read and answered the above questions to the best of my knowledge. I understand that I am ultimately financially responsible for all charges. By signing below I acknowledge my understanding of all terms and conditions.

_____ Date _____

Patient name printed

_____ Date _____

Patient signature

~ We are happy to assist you with your insurance; However your co-pay is due the day services are rendered ~

Financial Policy

Your financial responsibilities are not only important to you, but also they are an essential part of your care and treatment. Should you have any questions about our financial policy, please do not hesitate to ask.

Payments are due in full at the time of service and can be made in the form of:

- Cash.
- Check.
- All Major Credit Cards (American Express, Discover, Mastercard, or Visa).
- Monthly payment options through outside financing such as Care Credit or Chase Healthcare financing.

***** Any appointment scheduled for 90 minutes or greater will require a deposit equal to 20% of your portion of the scheduled treatment. In the event that the appointment is cancelled within 48 hours of the scheduled appointment time, your deposit is non-refundable. *****

When your portion of the investment is \$200.00 or greater, you can receive a five percent reduction on the amount you pay if it is paid in full at least one day prior to treatment.

Recommendations for your care are based on what you need and want, as opposed to your insurance benefits. We also understand the need for comfort with your payment options. That is why we work with you to maximize your insurance benefits so you can have a treatment plan that fits within your budget.

You are our valued patient. Therefore, you are responsible for the total treatment fee. As a courtesy to you, we accept assignment of benefit payments from most insurance companies. ***However, keep in mind that if you do not inform us of any special requirements in your plan, and the service we perform is denied, you are responsible for paying for the treatment. We allow 60 days for your insurance company to make a payment. At this time all unpaid balances become your responsibility.***

Patient Name

Date