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

Employer _____ Employer Address _____ Position _____
City State

Referred by? (circle one) Website / Mail Flier / Facebook / Ins Co / Location / Patient _____ Other:_____
Their Name

Emergency contact _____ Relationship _____ Phone Number _____

Spouse's Name _____ Birth date _____ 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:

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

Other Conditions:
_____
_____
_____
_____

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 could change anything about your smile, what would it be?

_____

_____

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:

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

Financial Policy

Your financial responsibilities are not only important to you; they are also 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).
- Care Credit

When your portion of the investment is $500.00 or greater, Santa Fe Dental requires a 20% deposit to schedule the appointment. This deposit is refundable up until 48 hours prior to your appointment. Patients may also receive a five percent discount on the total investment amount if paid in full at least one day prior to the appointment.

Recommendations for your care are based on the needs of your oral health and not on your insurance benefits. However, we will try our best to work with you to maximize your insurance benefits so you can have a treatment plan that fits within your *budget*.

You are responsible for the total treatment fee. As a courtesy to you, we accept assignment of benefit payments from most insurance companies. We are happy to assist you with your insurance; however, your co-pay is due the day services are rendered. **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 90 days for your insurance company to make a payment. At this time all unpaid balances become your responsibility.**

_____

Patient Name Date

Cancellation Policy

When you schedule an appointment at Santa Fe Dental, we reserve a specific time-slot and chair just for you. In order to best serve our patients, Santa Fe Dental requires a **48 hours** notice for any changes to your appointment. This includes cancellations, no shows and rescheduling. This gives us the appropriate amount of time to fill your reservation. Patients who are unable to honor the 48 hours notice will be charged a **$45.00** per hour fee to their account. This fee is not applicable to an appointment that requires a deposit as stated in the Financial Policy as this deposit would then be non-refundable.

To avoid any unwanted charges to your account, please be sure to contact our office at (405) 844-6100 at least 48 hours prior to your reserved appointment time.

I acknowledge and agree to the terms of Santa Fe Dental's Cancellation Policy.

_____

Patient Name Date