



**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:

- |   |  |  |  |
|---|--|--|--|
| <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 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:

- |  |  |  |
|--|--|--|
| <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/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.**

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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.**

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Patient Name

Date