TriState Family Dental Centers - Health History

Patient Name: Acct.#:

Please fill in the blank.

Do you have any artificial joints? ___________________

If yes, when was it done? ___________________________

Name of Surgeon:

Have you ever been told to take antibiotics before a dental appointment?

Are you taking a blood thinner? ___________________

If yes, name of medication.

Have you ever had cancer? ________________________

Have you had radiation therapy to the neck/head?

If yes, when? ____________________________________

Chemotherapy?

Are you currently taking or have you ever taken Bis-phosphonates for osteoporosis, multiple myeloma or other cancers, (i.e. Fosamax, Actonel, Boniva Aredia, Zometa)?

Are you currently under a doctor's care for any on-going health issues? ____________________________

If yes, explain:

Have you been hospitalized in the last two years?

If yes, explain:

Are you on a special diet? ________________________

If yes, explain:

Do you smoke or chew tobacco? _________________

If yes, how long?

How long has it been since your last dental visit?

Have you ever had any problems associated with any previous dental treatment? _________________

If yes, explain:

Please circle yes (Y) or no (N) for each.

Condition		
Heart Trouble/Disease	Y	N
Angina (Chest pain)	Y	N
Artificial heart valve	Y	N
Heart Murmur	Y	N
Cardiac Pacemaker	Y	N
Mitral Valve Prolapse	Y	N
Rheumatic Fever	Y	N
Arthritis	Y	N
Stroke	Y	N
High Blood Pressure	Y	N
Venereal Disease	Y	N
HIV/AIDS	Y	N
Hepatitis A	Y	N
Hepatitis B or C	Y	N
Autoimmune Disease	Y	N
Epilepsy or Seizures	Y	N
Diabetes	Y	N
Blood Disorder	Y	N
Alcoholism	Y	N
Drug Addiction	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
Eating Disorder	Y	N
Frequent or recurring mouth sores ...	Y	N

Clicking, popping or pain in the jaw joint	Y	N
Grinding or clenching teeth	Y	N
Dry mouth	Y	N

Do you take any medications on a regular basis? Please list medication below:

____

____

____

____

____

Are you allergic to any of the following?

Allergy		
Local Anesthetic	Y	N
Penicillin	Y	N
Aspirin	Y	N
Novocaine	Y	N
Sulfa	Y	N
Codeine	Y	N
Metal	Y	N
Latex Rubber	Y	N
Acrylic	Y	N
Costume Jewelry	Y	N

Other Allergies:

____

Women Only:

Pregnant	Y	N
Trying to get pregnant	Y	N
Nursing	Y	N
Taking Birth Control	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:** ___________________________ ______________________

TriState Family Dental Centers - Patient Registration

Account # : Date: Scanned By:

Patient Legal Name: ______________________________
Nickname/Preferred Name: ______________________
Date of Birth: _______________ Please Circle: M F
Please Circle: Married Single Minor Other
Address: _______________________________________
City, State, Zip: _________________________________
Home Phone # : _________________________________
Work Phone # : _________________________________
Cell Phone # : __________________________________
May we text/email you appointment reminders? Y N
Preferred contact number? Cell Home Work
Email: ____
SS#: ________________ Occupation: ______________
Employer: ______________________________________
Employer Address: _______________________________
Emergency Contact: ______________________________
Emergency Contact Phone # : ______________________
Emergency Contact Relationship: ___________________
Primary Care Physician: ___________________________

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

Name: ____
D.O.B. : ___________ SS# _______________________
Phone # : ____
Address : ____
Employer: ____

Name: ____
D.O.B. : ___________ SS# _______________________
Phone # : ____
Address : ____
Employer: ____

Please list below any family members who are also patients.

____
____
____

How did you hear about us?

__ Website __ Employer
__ Radio __ Location
__ Phonebook __ Newspaper
__ Patient __ Physician

Dental Insurance Information

Primary Ins. Co. Name: ____________________________
Insurance Co. Phone #: ____________________________
Insurance Co. Address : ____________________________
____
ID # : ____
Group #: ____
Subscriber Name: ___________________________________
Subscriber D.O.B. :__________________________________
Subscriber SS# : ____________________________________
Subscriber Employer: ________________________________

Secondary Ins. Co. Name: ___________________________
Insurance Co. Phone #: ______________________________
Insurance Co. Address : _____________________________
____
ID # : ____
Group #: ____
Subscriber Name: ___________________________________
Subscriber D.O.B. :__________________________________
Subscriber SS# : ____________________________________
Subscriber Employer: ________________________________

Is there anyone else we may speak to regarding your financial information, treatment and medical history? Spouses, other family members and/or friends must be listed if you would like us to speak with them regarding your information.

Name: Name:

Relationship: Relationship:

Financial Responsibility Agreement and Assignment of Insurance Benefits

I understand that I am ultimately financially responsible for any charges incurred at TriState Family Dental Centers either by myself or any underage minor in my care. I hereby authorize my signature on all insurance forms at the offices of TriState Family Dental Centers for payment directly to them for services rendered. I authorize TriState Family Dental Centers to send copies of dental records that may be needed to file my insurance claims. I understand that I am responsible regardless of whether or not my insurance pays. I understand that office policy requires payment in full for 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 for collection to obtain judgement or otherwise satisfy payment of my account, a collection fee of 33.33% will be added to my account. I understand and agree to the above terms.

Signature: ____ **Date:** ___________________________