

1**About You**

Today's Date: _____

Last Name: _____	First Name: _____
I prefer to be called: _____	Gender: _____
Birthday: _____	Age: _____
Address: _____	City: _____
State: _____	Zip Code: _____
Home Phone: _____	Cell Phone: _____
SSN: _____	Marriage Status: _____
DL#: _____	Email: _____

Employer: _____	Occupation: _____
Address: _____	City: _____
State: _____	Zip Code: _____
Length of employment: _____	Work Phone: _____

Previous/Present Dentist: _____	Last Visit: _____
Whom may we thank for referring you?: _____	
<input type="checkbox"/> Social Media <input type="checkbox"/> Insurance <input type="checkbox"/> Internet/Google <input type="checkbox"/> Family/Friend/Co-Worker	
Do you have other family members seen by us?: _____	

2**Spouse Information**

His/Her name: _____	Employer: _____
Work Phone: _____	SSN: _____
Birthdate: _____	DL#: _____

3**Emergency Contact**

His/ Her Name: _____ Relation: _____

Work Phone: _____ Home Phone: _____

4**Dental Insurance****Primary Carrier**

Insurance Co. Name: _____

Telephone: _____

Insured's Name: _____

Relation: _____

Insured's Birthdate: _____

Insured's ID#: _____

Group/ Policy #: _____

Insured's Employer: _____

Secondary Carrier

Insurance Co. Name: _____

Telephone: _____

Insured's Name: _____

Relation: _____

Insured's Birthdate: _____

Insured's ID#: _____

Group/ Policy #: _____

Insured's Employer: _____

5**Medical History**

Do you have a personal Physician? _____ Physician's name: _____

Phone: _____ Last visit date: _____

Are you currently under the care of this Physician? _____

If Yes, please explain: _____

Your current physical health is? _____

Are you currently pregnant/breastfeeding? _____

Are you taking any prescription / over the counter or herbal supplement drugs? If yes, please list

Do you smoke or use tobacco in any form? _____

5 (Medical History Continued)

Have you ever taken Phen-Fen? (Also known as Redux or Ponclimin) If Yes, when? _____

Have you ever had Osteoporosis or a bone disorder, and received any bisphosphonate drugs? (EX: Fosamax, Boneva, Skelid, Actonel, or Diodronel) _____

Have you ever taken IV drugs for Metastatic bone cancer? (EX: Zomet or Aredia) _____

Have you ever suffered from Congenital Heart disease?
Bacterial Endocarditis, or Atrial Septal Malformation? _____

Please list any medical condition(s) that you have ever had: _____

Have you ever had any of the following diseases or medical problems?

___ Yes ___ No	Abnormal Bleeding	___ Yes ___ No	Herpes/Fever Blisters
___ Yes ___ No	Alcohol/Drug Abuse	___ Yes ___ No	High Blood Pressure
___ Yes ___ No	Anemia	___ Yes ___ No	HIV+/AIDS
___ Yes ___ No	Arthritis	___ Yes ___ No	Hospitalized for any Reason*
___ Yes ___ No	Artificial Bones/Joints/Valves	___ Yes ___ No	Kidney Problems
___ Yes ___ No	Asthma	___ Yes ___ No	Liver Disease
___ Yes ___ No	Blood Transfusion	___ Yes ___ No	Low Blood Pressure
___ Yes ___ No	Cancer/ Chemotherapy	___ Yes ___ No	Lupus
___ Yes ___ No	Colitis	___ Yes ___ No	Pacemaker
___ Yes ___ No	Congenital Heart Failure	___ Yes ___ No	Psychiatric Problems
___ Yes ___ No	Diabetes	___ Yes ___ No	Radiation Treatment
___ Yes ___ No	Difficulty Breathing	___ Yes ___ No	Rheumatic/Scarlet Fever
___ Yes ___ No	Emphysema	___ Yes ___ No	Seizures
___ Yes ___ No	Epilepsy	___ Yes ___ No	Shingles
___ Yes ___ No	Fainting Spells	___ Yes ___ No	Sickle Cell Disease
___ Yes ___ No	Frequent Headaches	___ Yes ___ No	Sinus Problems
___ Yes ___ No	Glaucoma	___ Yes ___ No	Stroke
___ Yes ___ No	Hay Fever	___ Yes ___ No	Thyroid Problems
___ Yes ___ No	Heart Attack	___ Yes ___ No	Tuberculosis (TB)
___ Yes ___ No	Heart Surgery	___ Yes ___ No	Ulcers
___ Yes ___ No	Hemophilia	___ Yes ___ No	Venereal Disease
___ Yes ___ No	Hepatitis	*Reason	

Are you allergic to any of the following?

___ Yes ___ No	Aspirin	___ Yes ___ No	Latex
___ Yes ___ No	Codeine	___ Yes ___ No	Penicillin
___ Yes ___ No	Dental Anesthetics	___ Yes ___ No	Tetracycline
___ Yes ___ No	Erythromycin	___ Yes ___ No	Other*
___ Yes ___ No	Jewelry/Metals	*	

6

Dental History

Why have you come to the dentist today?	
Has your doctor told you that you require antibiotics before dental treatment?	_____ Yes _____ No
Are you currently in pain?	_____ Yes _____ No
Have you ever had a serious/difficult problem associated with any previous dental work?	_____ Yes _____ No
Do you have or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)?	_____ Yes _____ No
Your current dental health is:	_____ Good _____ Fair _____ Poor
Do your gums ever bleed?	_____ Yes _____ No
How many times a day do you brush?	
How often do you floss?	
What would you like to change about your smile? <input type="checkbox"/> Nothing, I am happy with my smile	
<input type="checkbox"/> Color <input type="checkbox"/> Bite <input type="checkbox"/> Chipped Teeth <input type="checkbox"/> Spaces <input type="checkbox"/> Crowding <input type="checkbox"/> Smile Makeover <input type="checkbox"/> Missing Teeth <input type="checkbox"/> Whiter Teeth	

7

Sleep History

Do you snore or have you been told you snore?	_____ Yes _____ No
Do you feel rested after a night's sleep?	_____ Yes _____ No
Have you been diagnosed with sleep apnea?	_____ Yes _____ No
Do you wear a C-PAP?	_____ Yes _____ No
Have you wore a C-PAP in the past?	_____ Yes _____ No
Have you been recommended to wear a C-PAP?	_____ Yes _____ No
Have you had a sleep study or been recommended to have one done?	_____ Yes _____ No

8

Confirmation

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Payment is due in full at time of treatment unless prior arrangements have been approved.

Our office is HIPPA Compliant and committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

Signature

Date

OFFICE POLICIES

Thank you for choosing Drs. Stranigan, Askeland & Harris as your dental health care providers. We are committed to giving you comfortable, quality treatment. Thank you for completing a medical history form, so that we can give you the best care possible. We now want to provide you with information regarding our office policies, including payment, insurance and appointment information.

Payment information:

- ❖ Payment is expected in full at time of visit
- ❖ We gladly accept Cash, Check, MasterCard, Visa, Discover, and American Express
- ❖ We participate with third party financing companies, Care Credit and Lending Club

Please check if you would like more information about our third party financing options:

- Care Credit Lending Club

Do you have insurance?

- ❖ We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company.
- ❖ As a courtesy to you, we will help you process all your insurance claims. Please understand that we will provide an insurance estimate to you, however it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits will determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible. If your insurance company has not made payment within 60 days, we will ask you to contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.
- ❖ We ask that you pay the deductible and co-payment. This is the **estimated** amount, not covered by your insurance company. You may pay this by cash, check, credit card or third party financing at the time we provide the service to you.
- ❖ We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

Appointment reminders:

- ❖ Our office may attempt to contact you via postcard, text and/or phone to confirm your upcoming appointment. We understand that unforeseen circumstances happen from time to time, however we ask that you **please contact our office at least 2 business days in advance should there be a change in your schedule.**

We are pleased to have you as a patient of our practice and look forward to taking care of your smile!

Consent:

I have read, understand and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to my dental office. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered. I further understand that a finance, rebilling, collection charge and/or attorney fee will be added to any overdue balance. By signing below, you are authorizing us to call you at any number you provide including calls to mobile/cellular or similar devices for any lawful purpose. You agree to any fees or charges that you may incur for an incoming call from us, and/or outgoing calls to us, to or from any such number, without reimbursement from us.

Signature

Date

S.A.H Dentistry

Your Privacy Is Important To Us

Acknowledgement of Receipt of Notice of Privacy Policies

I, _____ (Patient's Name) understand that as part of my health care, S.A.H. Dentistry originates and maintains health records by describing my health history, symptoms, examinations, test results, diagnosis, treatment and any plans for future care or treatment. I acknowledge that I have been provided with, and understand that S.A.H. Dentistry's Notice of Privacy Practices provides a complete description of the uses and disclosures of my health information.

I understand that:

_____ (Initials) I have the right to review S.A.H. Dentistry's Notice of Privacy Practices prior to signing this acknowledgement.

_____ (Initials) I **DO NOT** wish to receive a copy of this Dental Practice's HIPPA Notice of Privacy Practices

_____ (Initials) S.A.H. Dentistry may contact me via mail, home phone, cellular phone, email to remind me of appointments

Signature of Individual or Legal Representative Witness X _____

Printed Name of Individual Name or Legal Representative Witness X _____

Date: ____/____/____

Please list authorized persons with whom we may discuss your Protected Health Information (PHI) in addition to custodial parents and legal guardians:

1. _____ Added/Removed Date ____/____/____

2. _____ Added/Removed Date ____/____/____

3. _____ Added/Removed Date ____/____/____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but it could not be obtained because:

- Individual refused to sign
- Communication barrier prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (please specify) _____

Staff person initials _____