MEDICAL HISTORY FORM Date: _____

Name _____ Home Phone _____
Last First MI

Address _____ Work Phone _____

City/State _____Zip Code_____ Cell Phone_____

Date of Birth _____ /_____/_____ Sex ○M ○F **SSN**_____

Employer _____

Emergency Contact Person _____ Phone _____

Chief Complaint: _____

Referred by:_____

Dental Insurance _____ *Phone*_____

Subscriber Name _____*SSN/ID#*_____

*Date of Birth*_____*Employer*_____

IN THE FOLLOWING QUESTIONS, CHECK "YES" OR "NO", WHICHEVER APPLIES. YOUR ANSWERS ARE FOR OUR RECORDS ONLY AND WILL BE CONSIDERED CONFIDENTIAL INFORMATION.

1. Has there been any change in your general health within the past year? ○ YES ○ NO
2. Date of last physical examination: _____
3. Are you now under the care of a physician? ○ YES ○ NO
   -If yes, for what condition are you being treated? _____
4. Name and phone # of your physician _____
   _____
5. Have you had any serious illness or been hospitalized in the past 5 years? ○ YES ○ NO
   -If yes, what was the nature of the problem _____

6. Do you require **antibiotic** pre-medication <u>prior</u> to dental procedures? ○ YES ○ NO

7. Do you have or ever had any of the following conditions?
   - ○ YES ○ NO Heart murmur
   - ○ YES ○ NO Rheumatic Heart Disease
   - ○ YES ○ NO Mitral Valve Prolapse
   - ○ YES ○ NO Cardiovascular disease (heart attack, stroke, bypass)
   - ○ YES ○ NO High or Low blood pressure (**circle one**)
   - ○ YES ○ NO Joint or organ replacement (**circle one**)
   - ○ YES ○ NO Seasonal Allergies
   - ○ YES ○ NO Asthma
   - ○ YES ○ NO Seizures
   - ○ YES ○ NO Persistent diarrhea or recent weight loss

-OVER-

○ YES	○ NO	Diabetes
○ YES	○ NO	Hepatitis
○ YES	○ NO	Liver disease
○ YES	○ NO	Substance abuse
○ YES	○ NO	Thyroid problems
○ YES	○ NO	Respiratory problems
○ YES	○ NO	Arthritis
○ YES	○ NO	Ulcers
○ YES	○ NO	Kidney problems
○ YES	○ NO	Tuberculosis
○ YES	○ NO	Problems with immune system
○ YES	○ NO	Persistent swollen glands in neck
○ YES	○ NO	Cancer
○ YES	○ NO	Sexually transmitted disease
○ YES	○ NO	Epilepsy
○ YES	○ NO	Mental health problems
○ YES	○ NO	Anemia
○ YES	○ NO	Abnormal Bleeding

8. Are you allergic to or have you had a reaction to:

○ YES	○ NO	Local anesthetics
○ YES	○ NO	Penicillin
○ YES	○ NO	Sulfa drugs
○ YES	○ NO	Barbiturates, Sedatives or Sleeping pills
○ YES	○ NO	Aspirin
○ YES	○ NO	Iodine
○ YES	○ NO	Codeine

Other _____

9. Are you taking any medications including any non-prescription medications? ○ YES ○ NO
   Please list: _____
10. Have you had any trouble associated with any previous dental treatment? ○ YES ○ NO
   If so, explain: _____
11. Do you have any disease, condition or problem not list above? ○ YES ○ NO
   If so, explain: _____
12. Are you wearing contact lenses? ○ YES ○ NO
13. Are you wearing removable dental appliances? ○ YES ○ NO
14. Do you smoke or have a tobacco habit? ○ YES ○ NO

Women Only

15. Are you pregnant? ○ YES ○ NO
16. Are you nursing? ○ YES ○ NO
17. Are you taking birth control pills? ○ YES ○ NO

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his staff, responsible for any error or omissions that I may have made in the completion of this form.

_____*Date*_____

Signature of Patient

PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree than you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____

Anderegg & Thomas

Periodontics – Implants

FINANCIAL ARRANGEMENTS

DENTAL INSURANCE

We are happy to file the forms necessary to see that you receive the full benefits of your insurance policy coverage; **however we can make no guarantee of any estimated coverage**. Because the insurance policy is an agreement between you and the insurance company, **we ask that all patients be directly responsible for all charges** .We ask that a co-payment and the deductible be paid at the time of service. We do not file secondary insurance, but we will provide the necessary information for you to collect from your insurance provider. Please know that we will do everything possible to see that you receive the full benefits of your policy**.**

METHODS OF PAYMENT

1. Cash, Check or Credit Card (MasterCard or Visa)
2. Dental Insurance
3. Payment Plan (3rd party financing)- For patients who desire a monthly payment plan we have arrangements with a finance company (Care Credit). There are no application fees, no down payment is necessary and the loan can be interest-free. Applications are available from our front desk staff and approval is provided quickly.

RELATED INFORMATION

I understand that I am responsible for all charges incurred. I agree to pay finance charges on any balance that is over 90 days at 12% annually. I understand that any returned check will accrue a $20.00 service charge. I agree to pay any collection fees or attorney expenses should it be necessary to refer this account to a collection agency and I understand that any unpaid accounts will be reported to credit bureaus.

_____ _____

Patient or responsible party Date