Health Information

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain:_____

- Are you allergic to any medications or substances? ☐ Yes ☐ No
  If yes, please check any boxes that apply:
  ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal/Nickle ☐ Latex ☐ Other: _____

- Women (please check all that apply)
  ☐ Pregnant/trying to get pregnant ☐ Nursing ☐ Taking oral contraceptives

- Are you currently taking any medications, vitamins, herbs, pills, or drugs? ☐ Yes ☐ No
  If yes, please list:_____

- Are you currently under the care of a physician? ☐ Yes ☐ No
  If yes, please explain reason:_____

- Name of Physician: _____ Phone:_____

- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain:_____

Have you ever had/taken any of the following? Please check those that apply:

- ☐ Heart Disease/Surgery
- ☐ Heart Murmur or Defect
- ☐ Irregular Heart Beat
- ☐ Angina/Chest Pain
- ☐ Heart Attack/Failure
- ☐ Congenital Heart Disorder
- ☐ Mitral Valve Prolapse
- ☐ Rheumatic Fever
- ☐ Artificial Heart Valve
- ☐ Heart Pace Maker
- ☐ Pulmonary Shunt
- ☐ Low Blood Pressure
- ☐ Bacterial Endocarditis
- ☐ Bruise Easily
- ☐ Blood Disease
- ☐ Anemia
- ☐ Coronary Stent
- ☐ Excessive Bleeding
- ☐ Blood Thinners
- ☐ Hemophilia
- ☐ Methemoglobinemia
- ☐ Leukemia
- ☐ Recent Blood Transfusion
- ☐ High Blood Pressure
- ☐ Swelling of Limbs
- ☐ Lung Disease
- ☐ Breathing Problems
- ☐ Shortness of Breath
- ☐ Frequent Cough
- ☐ Hay Fever
- ☐ Sinus Trouble
- ☐ Asthma
- ☐ Bloody Sputum
- ☐ Emphysema
- ☐ X-Ray Treatments (Radiation)
- ☐ Chemotherapy
- ☐ Osteoporosis
- ☐ Bisphosphonates (Bone Loss)
- ☐ Osteonecrosis of Jaw
- ☐ Intestinal Disease
- ☐ Ulcers
- ☐ Recent Weight Loss
- ☐ Frequent Diarrhea
- ☐ Diabetes
- ☐ Excessive Thirst
- ☐ Hypoglycemia
- ☐ Sickle Cell Disease
- ☐ Tuberculosis
- ☐ Cancer
- ☐ Liver Disease
- ☐ Hepatitis A (Infectious)
- ☐ Hepatitis B and C
- ☐ Protease Inhibitor
- ☐ Night Sweats
- ☐ Yellow Jaundice
- ☐ Kidney Problems
- ☐ Renal Dialysis
- ☐ Thyroid Disease
- ☐ Cortisone Medicine
- ☐ Artificial Joint
- ☐ Sexually Transmitted Disease
- ☐ AIDS
- ☐ HIV Positive
- ☐ Genital Herpes
- ☐ Drug Addiction/Alcoholism
- ☐ Tattoos/Body Piercing
- ☐ Cold Sores
- ☐ Fever Blisters
- ☐ Psychiatric Care
- ☐ Intestinal Disease
- ☐ Parathyroid Disease
- ☐ Arthritis/Gout
- ☐ Rheumatism
- ☐ Herpes
- ☐ Stroke
- ☐ Convulsions
- ☐ Epilepsy or Seizures
- ☐ Fainting or Dizziness
- ☐ Glaucoma
- ☐ Tumors or Growths
- ☐ Nervousness
- ☐ Alzheimer's Disease
- ☐ Allergies (Medicines)
- ☐ Allergies (Pollen/Dust)
- ☐ Hives or Rash
- ☐ Pre-Medication
- ☐ Fen-phen
- ☐ OTHER:_____
  _____

(For office use only)
BP: _____
P: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

X_____ Date:_____
Printed name of patient

X_____
Signature of patient, parent or guardian

Dental Information

- Do you have a specific dental problem? ☐ Yes ☐ No
  If yes, please explain:_____

- Do you have dental examinations on a routine basis? ☐ Yes ☐ No
  If yes, when was your last visit?:_____

- How often do you brush? _____ Floss?_____

- Do you like your smile? ☐ Yes ☐ No
  If no, please list:_____

- Have your past experiences in a dental office always been positive? ☐ Yes ☐ No
  If no, please explain:_____

- Do you wish to talk to the dentist privately about any problem? ☐ Yes ☐ No
  If yes, please explain:_____

Have you ever had any of the following dental concerns? Please check those that apply:

☐ Food catches between teeth
☐ Loose teeth
☐ Clicking/popping of jaw joints
☐ Discomfort in the jaw joints
☐ Grind teeth
☐ Smoke tobacco
☐ Chew tobacco
☐ Bleeding gums
☐ Sore gums

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my dental health, I will inform the doctors at the next appointment without fail.

X_____ Date:_____
Signature of patient, parent or guardian

X_____ Date:_____
Signature of Doctor

Consents

Welcome to Downtown Dental! Please take a few minutes to review the following financial agreement and Receipt of Notice of Privacy Practices. We hope you understand that our credit and collection policies are a necessary part of assuring the financial resources needed to maintain this office for our patients and the community. ***Please initial each paragraph.***

X_____ Charges for our dental services at our office are due and payable at the time the services are rendered. We accept cash, check, Visa, MasterCard, Discover, and Care Credit. Copays and deductible estimates are due at the time of service and, as a courtesy; we will submit the covered charges to your insurance and allow 45 days for payment. At that time you will be required to pay the full charges and settle with your insurance company. **Please understand that your insurance is an agreement between you and your insurance company to pay a certain amount for your care. Our bill for services is an agreement between you and our office.** You are responsible for the payment of your bill regardless of the status of your insurance claim. If unusual circumstances should make it impossible to meet our credit terms, please call or personally discuss the matter with our Patient Care Coordinator. This will avoid misunderstanding and enable you to keep your account in good standing. Accounts 90 days past due are referred to a collection agency or small claims court, unless prior arrangements have been made with our office. Also we will no longer be able to provide for your (dependent) care.

X_____ All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed.

X_____ 'I request that payment of authorized dental or any other applicable health insurance benefits be made either to me or on my behalf to Downtown Dental for any services provided to my dependent(s). I authorize any holder of dental/medical information about my dependent(s) to release any information needed to determine benefits or benefits payable for related services to the applicable insurance agencies.'

X_____ In order to be respectful of the doctor and all patients' time, kindly give sufficient notice if you are unable to keep your appointment. If appointments are rescheduled without **48 hours notice**, you may be charged a fee. If you miss three appointments without prior timely notice, you may be discharged from the practice. If more than **10 minutes late**, we may ask you to reschedule for another time.

If you should have any question regarding the above policies, please feel free to discuss it with our Patient Care Coordinator.

X_____ Date:_____
Signature of patient, parent or guardian