MEDICAL HISTORY FORM

Patient's Name (Please Print) **Date**

Height _____ Weight _____

For the following questions, circle yes or no, whichever apply. Your answers are for our records only and will be considered confidential. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health.

Yes No Are you in good health?
Yes No Has there been any change in your general health within the past year?
Your last physical examination was on: _____
Yes No Are you now under the care of a physician?
If so, what condition is being treated? Name and address of physician(s):
_____
Yes No Have you had any serious illness, operation or been hospitalized in the past five years? _____
Yes No Are you or have you ever taken a biophosphonate medication (eg. Fosamax, Actonel, Boniva, Zometa, etc.)
Yes No Have you ever been instructed to take an antibiotic prior to dental treatment?

Do you have or have you had any of the following diseases or problems?

Yes No Cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis or stroke)?
Yes No Tetralogy of fallot
Yes No Coronary palliative shunt or conduit repairs
Yes No Transposition of the Great Arteries
Yes No Single heart ventricle

Yes No Inborn heart defects
Yes No Cardiac pacemaker
Yes No Chest pain upon exertion
Yes No Low blood pressure (hypotension)
Yes No High blood pressure (hypertension)
Yes No Shortness of breath
Yes No Swelling in ankles
Yes No Emphysema, bronchitis, etc.
Yes No Asthma or hay fever
Yes No Cough that produces blood
Yes No Persistent cough
Yes No Sinus trouble
Yes No Tuberculosis
Yes No Allergy to local anesthetics
Yes No Penicillin or other antibiotic allergy
Yes No Sulfa drug allergy
Yes No Barbiturates or sedatives allergy
Yes No Aspirin sensitivity
Yes No Iodine allergy
Yes No Codeine or other narcotic allergy
Yes No Latex Allergy
Yes No Other allergies: _____
Yes No Immune system problems

Yes No Hepatitis, jaundice or liver disease
Yes No AIDS or HIV infection
Yes No Sexually transmitted disease
Yes No Persistent diarrhea or recent weight loss
Yes No Stomach ulcer or hyper acidity
Yes No Epilepsy or other neurological disease
Yes No Fainting spells or seizures
Yes No Blood disorder or anemia
Yes No Abnormal bleeding
Yes No Growth or tumor: _____
Yes No Cancer: _____
Yes No Diabetes
Yes No Thyroid problems
Yes No Kidney trouble
Yes No Artificial joint: _____
Yes No Arthritis or painful swollen joints
Yes No Contact lenses

Women:
Yes No Pregnant
Yes No Birth Control Pills
Yes No Nursing

Yes No Do you have any disease, condition or problem not listed above that you think we should know about?
_____
_____
_____
_____

Yes No Are you taking any medications including non-prescription medication?
If so, what medication(s) are you taking? (Please use the bottom of this page if you need more space)

Medication:	Dose:

I certify that I have read and understand the information on the reverse side. 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 errors or omissions that I have made in the completion of this form.

Patient's Signature (Guardian for Minors) **Date**

Additional signatures for future appointments:

Patient's Signature (Guardian for Minors) **Date**

Patient's Signature (Guardian for Minors) **Date**

Patient's Signature (Guardian for Minors) **Date**

Patient's Signature (Guardian for Minors) **Date**

Patient's Signature (Guardian for Minors) **Date**

Patient's Signature (Guardian for Minors) **Date**

Patient's Signature (Guardian for Minors) **Date**

DENTAL HISTORY FORM

Patient's Name (Please print) **Date**

Please check any of the following problems that apply to you

Sensitivity (hot, cold, sweet)	☐
Tooth pain or discomfort when chewing	☐
Headaches, earaches, neck pain	☐
Jaw joint pain	☐
Broken teeth or broken fillings	☐
Grinding or clenching teeth	☐
Bleeding, swollen or irritated gums	☐
Loose, tipped or shifting teeth	☐
Bad Breath or bad taste in your mouth	☐
Dentures	☐
Partial dentures	☐
Braces	☐
Periodontal (gum) treatments	☐

If I could change my smile, I would:

- ☐ Make them brighter
- ☐ Make them straighter
- ☐ Close spaces
- ☐ Replace black metal fillings with natural, tooth-colored fillings
- ☐ Repair chipped teeth
- ☐ Replace missing teeth
- ☐ Replace old crowns that don't match
- ☐ Have a smile makeover

If you could whiten your teeth for a cost anyone could afford, would you do it? Yes No
Do you smoke or use chewing tobacco? Yes No
If so, how much do you smoke/chew and how long have you smoked/chewed?_____

One a scale of 1 – 10, with 10 being the highest rating:

How important is your dental health to you? 1 2 3 4 5 6 7 8 9 10
How would you rate your current dental health? 1 2 3 4 5 6 7 8 9 10

Please share the following dates:

Your last cleaning _____
Your last oral cancer screening _____
Your last complete x-rays _____
Name of previous dentist _____
City_____ State _____

Why did you leave your previous dentist? _____

What is the most important thing to you about your future smile and dental health?

_____

What is the most important thing to you about your dental visit today?

_____

BELTLINE FAMILY DENTISTRY

Acknowledgement of Receipt of Notice of Privacy Practices

* You May Refuse to Sign This Acknowledgment*

I, _____, have been offered a copy of this office's Notice of Privacy Practices.

Print Name_____

Signature_____

Date_____

For Office Use Only

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

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

Patient Name _____ **Date of Birth** _____

Address _____ **Home Phone** _____

City, State & ZIP _____ **Work Phone** _____

Email Address _____ **Cell Number** _____

Height _____ Weight _____ Single _____ Married _____ Male Female

Are you covered by any dental insurance? Yes No Your Social Security#_____

Name of your employer: _____ Group # _____

Name of Spouse (if applicable) _____ Spouse's Work # _____

Spouse's Social Security # _____ Spouse's Date of Birth _____

Spouse's Employer _____

Is spouse covered by other insurance? If so, name of insurance company: _____

Name of closest relative not living with you? _____ Phone number _____

In case of emergency, who should be contacted? _____ Phone number _____

Who recommended this office? _____

We are proud to be a part of a team whose primary mission is to deliver the finest and most comprehensive dental care services today. We are concerned about your dental care and want to ensure you that it is performed in a responsible manner. In order to assist you with the investment in your dental health, we are providing the following payment options from which you may select a plan that best meets your needs. We accept cash, check, Master Card, VISA, Discover, American Express and Care Credit. You may apply for Care Credit in our office or at CareCredit.com. There will be a $25 charge on all returned checks .

Insurance: We understand the value of insurance benefits and will assist you in obtaining your maximum benefit. We will gladly process your insurance claim for you without charge and will also estimate your deductible and the portion that will not be covered by your insurance. All policies have limitations and most do not cover 100% of the fees for dental services. The estimated amount not covered by your insurance is due at the time of your treatment and may be paid by any one of the options listed above. Our estimates are subject to final approval by your insurance company; therefore, the amount due our office is subject to change. It is your responsibility to be familiar with your individual policy, deductible, exclusions, yearly maximum and percentage of coverage.

Truth and Lending Statement: A FINANCE CHARGE of 1 and 1/2% per month (which is an 18% annual percentage rate) will be added 25 days from statement date on any unpaid previous balance aged over 90 days. The FINANCE CHARGE is calculated by applying the rate of 1 and 1/2% to the previous balance after deducting all payments and other credits during the billing cycle. The FINANCE CHARGE so calculated is then included in the new balance. (Disclosure required by the Federal Consumer Credit Act.)

Telephone Consumer Protection Act: You agree, in order for us to service your account or to collect any amounts you may owe, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or e-mails, using any e-mail address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

Failed Appointment Charge Policy: We make every effort to honor all time commitments and request you extend the same courtesy to us. If for some reason you must change an appointment, we would appreciate several days notice. There will absolutely be no charge as long as we receive 24 hours notice. A $25 per half hour charge will be applied for a change in the hygiene schedule and a $65 per half hour charge will be applied for the doctor's schedule, if you fail to honor your scheduled appointment.

I HAVE READ AND UNDERSTAND THIS FINANCIAL POLICY.

Patient Signature_____ Date _____

FOR PATIENTS WITH INSURANCE:

I authorize release of any information relating to this claim to my insurance company, and I hereby authorize payment directly to David G. Hudson, D.D.S. of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment.

Patient Signature_____ Date _____