

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 | Do you have any disease, condition or problem not listed above that you think we should know about? |

- | | | |
|-----|----|---|
| 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 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** _____