Health History Form

Name: Todays Date:

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

E-mail:		Home Phone: *Include area code* ( )	Business/Cell Phone: *Include area code* ( )	
Address: *Mailing address*		City:	State:	Zip:
Occupation:		Height:	Weight:	Date of Birth: Sex: M F
SS# or Patient ID:	Emergency Contact:	Relationship:	Home Phone: *Include area code* ( )	Cell Phone: *Include area code* ( )

If you are completing this form for another person, what is your relationship to that person?

Your Name *Relationship*

Do you have any of the following diseases or problems: *(Check DK if you Don't Know the answer to the question)*	**Yes**	**No**	**DK**
Active Tuberculosis	☐	☐	☐
Persistent cough greater than a 3 week duration	☐	☐	☐
Cough that produces blood	☐	☐	☐
Been exposed to anyone with tuberculosis	☐	☐	☐

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Dental Information *Please mark (X) your responses to the following questions.*

	Yes	**No**	**DK**
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐
Do you drink bottled or filtered water?	☐	☐	☐
If yes, how often? (*Check one:*) DAILY ☐ / WEEKLY ☐ / OCCASIONALLY ☐			
Are you currently experiencing dental pain or discomfort?	☐	☐	☐

	Yes	**No**	**DK**
Do you have earaches or neck pains?	☐	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Do you brux or grind your teeth?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Do you participate in active recreational activities?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐

Date of your last dental exam:

What was done at that time?

Date of last dental x-rays:

What is the reason for your dental visit today?

How do you feel about your smile?

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

	Yes	**No**	**DK**
Are you now under the care of a physician?	☐	☐	☐

Physician Name: Phone: *Include area code* ( )

Address/City/State/Zip:

Are you in good health?	☐	☐	☐
Has there been any change in your general health within the past year?	☐	☐	☐

If yes, what condition is being treated?

Date of last physical exam:

	Yes	**No**	**DK**
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐	☐

If yes, what was the illness or problem?

Are you taking or have you recently taken any prescription or over the counter medicine(s)?	☐	☐	☐

If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements:

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

(Check DK if you Don't Know the answer to the question)

Do you wear contact lenses? Yes ☐ No ☐ DK ☐

Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? Yes ☐ No ☐ DK ☐

Date: _____ If yes, have you had any complications? _____

Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax®, Actonel®, Atelvia, Boniva®, Reclast, Prolia) for osteoporosis or Paget's disease? Yes ☐ No ☐ DK ☐

Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia®, Zometa®, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? Yes ☐ No ☐ DK ☐

Date Treatment began: _____

Do you use controlled substances (drugs)? Yes ☐ No ☐ DK ☐

Do you use tobacco (smoking, snuff, chew, bidis)? Yes ☐ No ☐ DK ☐
If so, how interested are you in stopping?
Circle one: VERY / SOMEWHAT / NOT INTERESTED

Do you drink alcoholic beverages? Yes ☐ No ☐ DK ☐

If yes, how much alcohol did you drink in the last 24 hours? _____

If yes, how much do you typically drink i n a week? _____

WOMEN ONLY Are you:

Pregnant? Yes ☐ No ☐ DK ☐
Number of weeks: _____
Taking birth control pills or hormonal replacement? Yes ☐ No ☐ DK ☐
Nursing? Yes ☐ No ☐ DK ☐

Allergies. Are you allergic to or have you had a reaction to:
To all **yes** responses, specify type of reaction.

	Yes	No	DK
Local anesthetics _____	☐	☐	☐
Aspirin _____	☐	☐	☐
Penicillin or other antibiotics _____	☐	☐	☐
Barbiturates, sedatives, or sleeping pills _____	☐	☐	☐
Sulfa drugs _____	☐	☐	☐
Codeine or other narcotics _____	☐	☐	☐
Metals _____	☐	☐	☐
Latex (rubber) _____	☐	☐	☐
Iodine _____	☐	☐	☐
Hay fever/seasonal _____	☐	☐	☐
Animals _____	☐	☐	☐
Food _____	☐	☐	☐
Other _____	☐	☐	☐

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No	DK
Artificial (prosthetic) heart valve	☐	☐	☐
Previous infective endocarditis	☐	☐	☐
Damaged valves in transplanted heart	☐	☐	☐
Congenital heart disease (CHD)			
Unrepaired, cyanotic CHD	☐	☐	☐
Repaired (completely) in last 6 months	☐	☐	☐
Repaired CHD with residual defects	☐	☐	☐

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

	Yes	No	DK
Cardiovascular disease	☐	☐	☐
Angina	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Congestive heart failure	☐	☐	☐
Damaged heart valves	☐	☐	☐
Heart attack	☐	☐	☐
Heart murmur	☐	☐	☐
Low blood pressure	☐	☐	☐
High blood pressure	☐	☐	☐
Other congenital heart defects	☐	☐	☐
Mitral valve prolapse	☐	☐	☐
Pacemaker	☐	☐	☐
Rheumatic fever	☐	☐	☐
Rheumatic heart disease	☐	☐	☐
Abnormal bleeding	☐	☐	☐
Anemia	☐	☐	☐
Blood transfusion If yes, date: _____	☐	☐	☐
Hemophilia	☐	☐	☐
AIDS or HIV infection	☐	☐	☐
Arthritis	☐	☐	☐
Autoimmune disease	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Systemic lupus erythematosus	☐	☐	☐
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐
Tuberculosis	☐	☐	☐
Cancer/Chemotherapy/ Radiation Treatment	☐	☐	☐
Chest pain upon exertion	☐	☐	☐
Chronic pain	☐	☐	☐
Diabetes Type I or II	☐	☐	☐
Eating disorder	☐	☐	☐
Malnutrition	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
G.E. Reflux/persistent heartburn	☐	☐	☐
Ulcers	☐	☐	☐
Thyroid problems	☐	☐	☐
Stroke	☐	☐	☐
Glaucoma	☐	☐	☐
Hepatitis, jaundice or liver disease	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Neurological disorders If yes, specify: _____	☐	☐	☐
Sleep disorder	☐	☐	☐
Do you snore?	☐	☐	☐
Mental health disorders Specify: _____	☐	☐	☐
Recurrent Infections Type of infection: _____	☐	☐	☐
Kidney problems	☐	☐	☐
Night sweats	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistent swollen glands in neck	☐	☐	☐
Severe headaches/ migraines	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
Excessive urination	☐	☐	☐

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? Yes ☐ No ☐ DK ☐

Name of physician or dentist making recommendation:

Phone: *Include area code*
( )

Do you have any disease, condition, or problem not listed above that you think I should know about? Yes ☐ No ☐ DK ☐
Please explain:

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: Date:

Signature of Dentist: Date:

FOR COMPLETION BY DENTIST

Comments:

INSURANCE INFORMATION

Parent/Guardian Info

Name of Person Responsible for this Account:		Relationship to Patient:
Address:		Home Phone:
Drivers License #:	Birthdate:	Financial Institution:
Employer:		Work Phone:
Social Security #:		

Primary Insurance

Name of Policy Holder:		Relationship to patient:	
Birthday:		Social Security #:	
Name of Employer:		Work Phone:	
Address of Employer:	City:	State:	Zip:
Insurance Company:	Insurance Co. Phone #:	Group #:	
Union or Local #:	ID #:		
Insurance Co. Address:	City:	State:	Zip:

Secondary Insurance

Nam of Policy Holder:		**Relationship to Patient**	
Birthday of Insured:		Social Security #:	
Name of Employer:		Work Phone:	
Address of Employer:	City:	State:	Zip:
Insurance Company:	Insurance Co. Phone #:	Group #:	
Union or Local #:	ID #:		
Insurance Co. Address:	City:	State:	Zip:

Our system only allows for us to submit to two insurances. If you have additional insurance, we can give you the info to submit that once the first two claims have been finalized.

Our Financial Policy

We are committed to providing you with the best possible care. If you have dental insurance, we are happy to help you receive the maximum allowable benefits. To achieve these goals, we need your understanding of payment policy. We thank you for taking the time to read and accept the policy below.

Non-Insured Patients

Payment is due at the time that services are rendered. For your convenience, we accept cash, personal checks, Visa, Discover, Mastercard, American Express, and Care Credit.

Insured Patients

As health care providers, our relationship s with you, not your insurance company.

Estimated co-insurance is due at the time services are rendered. We will gladly discuss your proposed treatment and answer any questions relating to your insurance to the best of our ability, however…

1. Your insurance is a contract between you, the insurance company, and your employer. We are not a party to that contract. The filing of insurance claims is a courtesy that we extend.
2. Our fees are considered to fall within the acceptable range by most insurance companies
3. Not all services rendered are a covered benefit in all contracts
4. Our estimate of insurance coverage is only an estimate based on the information available to us.

We realize that temporary financial problems may affect timely payment of your account. If problems do arise, please contact as soon as possible for the assistance in the management of your account.

All checks returned are subject to a $20.00 service charge

In the event that this agreement becomes a collections matter, the patient/guarantor shall be responsible for all charges and costs related to the collection activities.

I HAVE READ AND UNDERSTAND THE ABOVE POLICIES

Printed Name _____ Signature _____

Date_____

Walnut Family Dentistry
11336 S. 96th Street, Suite #121
Papillion, NE, 68046
402.964.2200
info@walnutdentistry.com

HIPPA Compliance Patient Consent Form

Our notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You are confirming, by your signature, that you have reviewed our notice before signing this consent. The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payments, or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Information Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations

By signing this form, you are consenting to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a reversal will only be effective from the date of signature.

By signing this form, I understand that:

- ☐ Protected health information may be disclosed or used for treatment, payment, or healthcare operations
- ☐ The practice reserves the right to change the privacy policy as allowed by law
- ☐ The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions
- ☐ The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- ☐ The practice may condition receipt of treatment upon execution of this consent

	YES	NO
May we phone, email, or send a text message to you to confirm appointments?	☐	☐
May we leave a message on your answering machine at home or on your cell phone?	☐	☐
May we discuss your medical conditions with any of your family members?	☐	☐

If Yes, please list the names of the members allowed:

_____

_____

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature: _____ Date:_____

Witness: _____ Date:_____

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Broken Appointment Policy

Our practice is growing every day. When a patient does not show up for their appointment, or cancels too close to their scheduled time, we are unable to fill this appointment with another patient who needs dental help

Broken Appointments:

- A broken appointment is any time that you are scheduled for an appointment, and you do not show up for that appointment.
- Late cancellations are considered broken appointments. If you need to cancel your appointment, we ask you to please call **at least 48 hours** prior to you scheduled appointment if you need to cancel. A broken appointment is considered anything less than **24 hours notice.**
- If you are more than 10 minutes late to your appointment, we will do our best to complete your dental services within the allowed time frame
- If you are more than 15 minutes late, we will need to reschedule your appointment, and it will be considered a "broken appointment."

Appointment Confirmation:

- We do our best to confirm your appointment the business day before your scheduled visit. This is done as a courtesy, and the patient is ultimately responsible for keeping that appointment. If you do not show up for your scheduled appointment, or you cancel less than 24 hours before the start of your appointment, it will be given to another patient. This will be considered a broken appointment. After the second missed appointment, you will be asked to place a card on file for scheduling future appointments. A $50.00 fee will be charged to your card for every hour that you are scheduled for the missed appointment.

- If you miss an appointment or cancel late two times, and do not want to place your card on file, you can still receive treatment from our office. However, you will be placed on a "**same day appointment only**" status. This means you can call us on the morning of your intended visit for a "**same day appointment**." We will always do our best to work you into the schedule, if it does not interfere with the care of our previous scheduled patients. Please understand there is no guarantee you will receive an appointment on the same day.

Patient Signature:_____ Date:_____

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