NORTH APPLETON
DENTISTRY LLC
3521 COMMERCE CT – APPLETON, WI 54911 – (920)-734-7730

MEDICAL HEALTH HISTORY

Patient Name_____ **Date of Birth**___/_____/_____

Yes No Are you currently being treated by a doctor for something other than routine care *(reason?)*_____

If yes, Physician's Name: _____ Phone Number: _____

Please circle the correct response:

Yes No Do you have to take a Pre-medication prior to dental work? If Yes, did you take it today? **YES NO**

Yes No Are you allergic to any medications? List:_____

Yes No Are you sensitive to latex, metals, or other substances? List: _____

Yes No Women - Are you pregnant or trying to become pregnant? Women – Are you nursing? Yes No

Yes No Have you been told that you have or have you been treated for heart disease?

Yes No Do you have a pacemaker, cardiac stents or artificial heart valves? If yes, date of placement: _____

Yes No Do you have high or low blood pressure? HIGH LOW (If yes, please circle)

Yes No Have you had major illness or any surgery? What/When _____

Yes No Have you had radiation or chemotherapy? For what _____ _____

Yes No Have you taken any bisphosphonates? (Fosamax, Boniva, Zometa, Aredia) For how long? _____

Yes No Do you have artificial joints? If yes, date of placement: _____

Yes No Are you on any blood thinners (including daily aspirin)? List: _____

Yes No Have you had problems with excessive bleeding after a cut?

Yes No Do you have acid reflux or GERD?

Yes No Are you diabetic? Type I or II (circle) Medication _____

Yes No Do you have asthma or other respiratory problems? List: _____

Yes No Have you tested HIV positive or do you have ARC or AIDS?

Yes No Do you test positive for hepatitis? Circle which: A B C D

Yes No Do you use tobacco products? List which: _____ How much/day _____

Please list all prescription medications, supplements, or herbals you regularly take below:

(or provide a copy of your complete medication/surgery list)

.....	.....	.....
.....	.....	.....
.....	.....	.....
.....	.....	.....

(continue on backside)

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PLEASE CHECK ALL THAT APPLY:

☐ Pre-Med Amox	☐ Pre-Med - Clind	☐ Allergy - Erythro	☐ Acid Reflux
☐ Allergy - Sulfa	☐ Allergy - Codeine	☐ Allergy - Other	☐ Allergy - Hay Fever
☐ Allergy - Latex	☐ Allergy - Metals	☐ Allergy - Tetracycline	☐ Allergy - Penicillin
☐ Alzheimer's	☐ Allergy - NSAID Drugs	☐ Arthritis	☐ Allergy - Amox
☐ Artificial Joints	☐ Anemia	☐ Blood Disease	☐ Artificial Valve
☐ Cardiac Stents	☐ Asthma	☐ Dizziness	☐ Cancer
☐ Excessive Bleeding	☐ Diabetes	☐ Malignant Hypertherm	☐ Epilepsy
☐ Head Injuries	☐ Fainting	☐ Heart Murmur	☐ Glaucoma
☐ High Blood Pressure	☐ Heart Disease	☐ HIV	☐ Hepatitis
☐ Low Blood Pressure	☐ High Cholesterol	☐ Nervous Disorders	☐ Kidney Disease
☐ **Other – please explain below**	☐ Mental Disorders	☐ Pregnancy	☐ Osteoporosis
☐ Radiation/Chemo Tx	☐ Pacemaker	☐ Rheumatic Fever	☐ Psychiatric Tx
☐ Seizures	☐ Respiratory Problems	☐ Stomach Problems	☐ Stroke
☐ Takes Bisphosphonate	☐ Sinus Problems	☐ Tuberculosis	☐ Tumors
☐ Ulcers	☐ Thyroid Disease	☐ Venereal Disease	☐ Use Tobacco Products

If you marked "Other" please explain: _____

_____

Any other health information not covered that you'd like to share: _____

_____

_____

Patient Signature & Date

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DENTAL HEALTH HISTORY

Yes No Do you have any discomfort from your teeth or gums? Where: _____

Yes No Do your gums bleed or hurt when you brush or floss them? Where: _____

Yes No Does food catch between your teeth? Where: _____

Yes No Do you experience pain from heat, cold, or sweets? (Circle which one) Where: _____

Personal Dental History (Please check all that apply):

- ☐ Had an unfavorable dental experience
- ☐ Had trouble getting numb for treatment
- ☐ Had/have braces, orthodontic treatment
- ☐ Had any teeth removed
- ☐ Had complications from past dental treatment
- ☐ Had any reactions to local anesthetic
- ☐ Had your bite adjusted

Bite and Jaw Joint (Please check all that apply):

- ☐ You have problems with your jaw joint (noise or discomfort)
- ☐ You have problems chewing
- ☐ Your teeth changed in the last 5 years, become shorter, thinner, or worn
- ☐ Your teeth are becoming crowded or developing spaces
- ☐ You chew ice, bite your nails, use your teeth to hold objects or have any other oral habits
- ☐ You clench your teeth in the daytime or clench or grind your teeth at night
- ☐ You have headaches more than once a week
- ☐ You wear or have worn a bite appliance

Tooth structure (Please check all that apply):

- ☐ Cavities within past 3 years
- ☐ Your mouth is dry or you have difficulty swallowing any food
- ☐ You notice or have holes (i.e. pitting/craters) on the biting surface of your teeth
- ☐ Any teeth sensitivity to hot, cold, sweets, or avoid brushing part of your mouth
- ☐ Grooves or notches on your teeth, chipped teeth, or have a toothache or cracked filling
- ☐ Food gets caught between your teeth

If any of the checked boxes need further explanation, please describe:

_____

_____

_____

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FINANCIAL POLICY

As a condition of treatment by this office, arrangements for payment must be made in advance. Financial responsibility must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash or with a credit card at the time services are performed.

It is important that patients with dental insurance understand that all dental services are charge directly to the patient and that he or she is personally responsible for payment of all dental services. We will submit your dental claim to your insurance and credit any collections to your account. Patient copayments are payable at time of service, unless other financial arrangements have been made. If for any reason your insurance company denies your claim you are fully responsible for payment of services provided.

A $5 billing charge will be added monthly to all unpaid balances on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination. I further acknowledge that fee estimates are based on visual and x-ray assessment and that the actual condition of the tooth may be different and involve a different fee.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I understand the above information and agree with its contents. _____ _____
(Signature) (Date)

CONSENT TO TREATMENT

I consent to the diagnostic procedures and treatment by the dentist, hygienist and/or assistant necessary for proper dental care. I consent to the dentist's use and disclosure of my (or my child's) pertinent records to carry out treatment, consult with other practitioners, obtain payment and for those activities and health care operations related to treatment or payment. My consent to disclosure of records shall be effective until I revoke it in writing.

_____ By Initialing here, I understand the above information and agree with its contents.

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign the Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operation, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice is available at your request. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practice as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

Persons Involved in Care: By signing this form, you will consent to our use of your dental care records to the following persons, including those involved in your care or payment for that care. Please list the person(s) you would like involved in your care or payment for that care:

(Example: Spouse or Parents) _____
Name & Relationship to you

(Example: Spouse or Parents) _____
Name & Relationship to you

(Example: Spouse or Parents) _____
Name & Relationship to you

I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Print patient Name_____ **Date of birth** _____

_____
(Print Parent or Legal Guardian name if patient is a minor)

_____ _____
Signature **Date**

For Office Use Only

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

- ☐ Individual refused to sign
- ☐ Communications barrier prohibited obtaining acknowledgement
- ☐ Other (Please Specify) _____

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APPOINTMENT CANCELLATION POLICY

We understand that unplanned situations can come up and you may need to reschedule an appointment. If that happens, we respectfully ask for scheduled appointments to be rescheduled at least 24 hours in advance; 48 hours in advance if the appointment is scheduled for longer than two (2) hours. This will enable for another person who is waiting for an appointment to be scheduled in that appointment slot.

Our doctors and hygienists want to be available for your needs and the needs of all our patients. When a patient does not show up for a scheduled appointment, another patient loses an opportunity to be seen. Although we have always had a cancellation policy, circumstances have caused us to enforce a policy of charging for No Show appointments, and those appointments not rescheduled within 24/48 hours.

As of May 1, 2018 there will be a fee of **$25 per hour** of scheduled appointment time assessed if we do not receive a call to reschedule an appointment within 24/48 hours prior to the appointment time. Cancellation and No Show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment. These fees are not covered by insurance and will not be billed to your insurance company.

We understand that Special unavoidable circumstances may cause you to reschedule within 24/48 hours. Fees in this instance may be waived but only with management approval.

Thank you for being a valued patient and for your understanding and cooperation as we instituted this policy. This policy will enable us to open otherwise unused appointments to better serve the needs of all patients.

Please sign that you have read, understand, and agree to this Cancellation and No Show Policy.

_____ **Date of birth** _____

Patient Name (Please Print)

_____ _____

Signature of Patient or Legal Guardian **Date**

For Office Use Only

We attempted to obtain written acknowledgement our appointment cancellation and no show policy, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barrier prohibited obtaining acknowledgement
- ☐ Other (Please Specify)

_____