

MEDICAL HISTORY QUESTIONNAIRE – UPDATE

Name _____ () M () F Date of Birth _____

Address: _____ City, State, Zip: _____

Contact: Home Phone _____ Cell Phone _____ Work Phone _____

What is your estimate of your current health? Poor _____ Fair _____ Good _____

HAVE YOU EVER HAD THE FOLLOWING: YES NO YES NO

- | | | | | | |
|---|--------------------------|--------------------------|---|--------------------------|--------------------------|
| Hospitalization for illness or injury | <input type="checkbox"/> | <input type="checkbox"/> | Stomach or duodenal ulcer..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Allergic reaction to: | <input type="checkbox"/> | <input type="checkbox"/> | Arthritis..... | <input type="checkbox"/> | <input type="checkbox"/> |
| • Aspirin, Ibuprofen..... | <input type="checkbox"/> | <input type="checkbox"/> | Contact lenses..... | <input type="checkbox"/> | <input type="checkbox"/> |
| • Acetaminophen..... | <input type="checkbox"/> | <input type="checkbox"/> | Head or neck injury..... | <input type="checkbox"/> | <input type="checkbox"/> |
| • Penicillin..... | <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy, convulsions (seizures).. | <input type="checkbox"/> | <input type="checkbox"/> |
| • Sulfa..... | <input type="checkbox"/> | <input type="checkbox"/> | Viral infections or cold sores..... | <input type="checkbox"/> | <input type="checkbox"/> |
| • Codeine..... | <input type="checkbox"/> | <input type="checkbox"/> | Lumps or swelling in the mouth... | <input type="checkbox"/> | <input type="checkbox"/> |
| • Sedative..... | <input type="checkbox"/> | <input type="checkbox"/> | Hives, skin rash, hay fever..... | <input type="checkbox"/> | <input type="checkbox"/> |
| • Local Anesthetics..... | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis (type __)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| • Latex..... | <input type="checkbox"/> | <input type="checkbox"/> | HIV / AIDS..... | <input type="checkbox"/> | <input type="checkbox"/> |
| • Metals..... | <input type="checkbox"/> | <input type="checkbox"/> | Tumor or abnormal growth..... | <input type="checkbox"/> | <input type="checkbox"/> |
| • Any other allergies..... | <input type="checkbox"/> | <input type="checkbox"/> | Radiation therapy..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart problems..... | <input type="checkbox"/> | <input type="checkbox"/> | Chemotherapy..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart murmur..... | <input type="checkbox"/> | <input type="checkbox"/> | Emotional problems..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Rheumatic fever..... | <input type="checkbox"/> | <input type="checkbox"/> | Psychiatric treatment..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood pressure HIGH / LOW..... | <input type="checkbox"/> | <input type="checkbox"/> | Antidepressant treatment..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Pacemaker..... | <input type="checkbox"/> | <input type="checkbox"/> | Alcohol or drug dependency..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Stroke..... | <input type="checkbox"/> | <input type="checkbox"/> | Taken steroids within the last 2 years.. | <input type="checkbox"/> | <input type="checkbox"/> |
| Artificial joint or heart valve..... | <input type="checkbox"/> | <input type="checkbox"/> | Ever taken Bisphosphonates (IV or Oral | <input type="checkbox"/> | <input type="checkbox"/> |
| Date of placement _____ | | | (Actonel, Bonica, Fosamax, Skelid, Didronel, Aredia, Zometa, Bonefos) | | |
| Anemia or other blood disorders..... | <input type="checkbox"/> | <input type="checkbox"/> | ARE YOU: | | |
| Prolonged bleeding due to slight cut..... | <input type="checkbox"/> | <input type="checkbox"/> | Taking steroids..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Tuberculosis..... | <input type="checkbox"/> | <input type="checkbox"/> | Presently being treated for illness... | <input type="checkbox"/> | <input type="checkbox"/> |
| Asthma/Emphysema..... | <input type="checkbox"/> | <input type="checkbox"/> | Aware of a change in your health... | <input type="checkbox"/> | <input type="checkbox"/> |
| Sinus problems..... | <input type="checkbox"/> | <input type="checkbox"/> | Often exhausted or fatigued..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Kidney disease..... | <input type="checkbox"/> | <input type="checkbox"/> | Subject to frequent headaches..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Jaundice or Liver disease..... | <input type="checkbox"/> | <input type="checkbox"/> | A smoker – How many per day..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Thyroid or parathyroid disease..... | <input type="checkbox"/> | <input type="checkbox"/> | Are you anxious about dentistry..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Hormone deficiency..... | <input type="checkbox"/> | <input type="checkbox"/> | Easily upset..... | <input type="checkbox"/> | <input type="checkbox"/> |
| High cholesterol..... | <input type="checkbox"/> | <input type="checkbox"/> | FEMALE – use birth control pills... | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes..... | <input type="checkbox"/> | <input type="checkbox"/> | FEMALE – pregnant..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Glaucoma..... | <input type="checkbox"/> | <input type="checkbox"/> | MALE – have prostate disorder..... | <input type="checkbox"/> | <input type="checkbox"/> |

Please describe any current medical treatment, impending or recent surgery, or other treatment that may possibly affect your dental treatment. _____

List (or attach a separate list if extensive) any medications taken within the last two years. _____

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

SIGNATURE _____	DATE _____
SIGNATURE _____	DATE _____
SIGNATURE _____	DATE _____

DENTAL HISTORY

Referred by _____

Previous dentist _____

How long? _____

Last dental exam _____

Last dental x-ray _____

Last dental treatment _____

How often do you have your teeth cleaned? 3 mo _____ 4 mo _____ 6 mo _____ 1 year or longer _____

WHAT IS YOUR IMMEDIATE DENTAL CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

YES NO

- | | | |
|--|--------------------------|--------------------------|
| 1. Unhappy with the appearance of your teeth | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Unfavorable dental experiences | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Dental fears | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Problems with effectiveness or bad reactions to dental anesthetic | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Orthodontic treatment (braces) / when | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Periodontal (gum) treatment / when | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Bleeding gums | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Avoid brushing any part of your mouth | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Part of your mouth is sensitive to temperature | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Sore teeth | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. A burning sensation in your mouth | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Difficulty swallowing | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. An unpleasant taste or odor in your mouth | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Dry mouth..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Jaw problems (Temporomandibular joint) | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Difficulty opening your mouth widely | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Stiff neck muscles | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Awaken with an awareness of your teeth or jaws | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Tension headaches | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Clench or grind your teeth | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Jaw clicking or popping..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Lost any teeth | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Do you sweat or tremble a lot during examination | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. Do unfamiliar people or places make you uncomfortable | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. Are you happy with the color of your teeth | <input type="checkbox"/> | <input type="checkbox"/> |

SUPPLEMENTAL DENTURE HISTORY:

If you are wearing a partial or complete artificial denture, please complete the following:

- | | | |
|--------------------------|--------------------------|--|
| YES | NO | (Please check yes or no) |
| <input type="checkbox"/> | <input type="checkbox"/> | Has your present denture been relined? When? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Is your present denture a problem? Describe _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Satisfied with the appearance? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Satisfied with the comfort? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Satisfied with the chewing ability? _____ |
| | | When did you receive your first partial of complete denture? _____ |
| | | How long have you worn your present denture? _____ |

Patient's Signature _____ Date _____

Doctor's Remarks: _____

_____ Doctor's Signature _____

Person Responsible for Payment

Name: _____
Last First Middle

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-mail Address: _____

How would you like us to confirm your appointments? (Circle) Email Home Work Cell

Marital Status (Circle): Single Married Separated Divorced Widowed

Social Security #: _____ Sex (Circle): Male Female Birth Date: _____

Relationship to Patient (Circle): Self Spouse Child Other _____

Emergency Contact: _____
Name Address Phone #

Insurance

Primary Dental Insurance: _____ Subscriber Name: _____

ID #: _____ Birthdate: _____ Group #: _____ Employer: _____

Dental Insurance Mailing Address: _____

Secondary Dental Insurance: _____ Subscriber Name: _____

ID #: _____ Birthdate: _____ Group #: _____ Employer: _____

Dental Insurance Mailing Address: _____

I authorize the release of any medical or other information necessary to process my claims as well as payment of dental benefits to Dr. Wadhvani or Dr. Smith for services rendered. This authorization shall remain valid until such time as I request otherwise. _____

Office Financial Policy

I understand that payment in full is expected at the time of service for all appointments. Payment can be made by cash, check, or major credit card. Because we are a specialty office, many of our procedures fall into the category of elective dentistry and are not covered by insurance. We accept all PPO insurance plans, but are not contracted directly with any insurance company and are considered an out-of-network provider. All other insurance claims (including medical and accident claims) are the responsibility of the patient. Accounts over 30 days will accrue a monthly service charge of 1%. Unresolved accounts over 90 days due will be sent to a collection agency, interest and fees will be included.

Missed Appointment / Late Cancellations

Broken appointments represent a cost to us, to you and to the other patients who could have been seen in the time set aside for you. We require a **2 business day advanced notice** for any changes or cancellations of your appointments. As a courtesy, we make every effort to remind you of your appointments ahead of time; however, it is ultimately your responsibility to keep your appointments. There will be a \$75 fee for missed or short notice appointment cancellations.

Please sign below to acknowledge that you have read and agree to the above policy.

Signature _____ Date _____

NOTICE OF PRIVACY PRACTICES – ACKNOWLEDGMENT

We keep a record of the healthcare services we provide you. You can ask to see and copy that record. You can also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You can see your record or get more information about it by contacting our office.

Our Notice of Privacy Practices describes in more detail how your health information can be used and disclosed, and how you can access your information.

By my signature below, I acknowledge that I have read and understand the Notice of Privacy Practices of NW Prosthodontics. I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers for my health care services.
- Conduct normal health care operations such as quality assessment and improvement activities.
- Photos, slides, x-rays or any other viewings of my care and treatment during or after its completion to be used for the advancement of dentistry and reimbursement purposes. My identity will not be revealed to the general public, however, without my permission.

Patient or legally authorized individual signature

Date

Printed name if signed on behalf of the patient

Relationship

For Office Use Only:

We were unable to obtain the patient's written acknowledgment of our Notice of Privacy Practices due to the following reason:

- The patient refused to sign
- Communication barriers
- Emergency situation
- Other** _____

Missed Appointment Policy

We require a **two-business day** advanced notice for any changes or cancellations of your appointments. This allows us the time we initially reserved especially for you in our schedule to be filled by another patient who may have been waiting for this appointment time.

As a courtesy, we make every effort to remind patients of their appointments ahead of time; however, it is ultimately the patient's responsibility to keep their appointments.

- If you notify us 2 business days in advance of canceling your appointment or reschedule for the same day, there will be no charge assessed.
- If you do not call within 2 business days or "no show" your appointment you may be assessed a \$75 cancellation fee. This is not covered by your insurance, but will be paid by you directly. Cancellation fees must be paid prior to the start of your next appointment.
- Excessive abuse of scheduled appointments may result in discharge from the practice.

By signing below, I acknowledge that I have read and agree to the above policy.

Signature _____ Date _____

WHAT IS THE BEST WAY TO CONFIRM YOUR APPOINTMENTS?

Home / Work / Cell / Email _____