PATIENT MEDICAL HISTORY

Name ____ Date of birth____________________

Do you have any CURRENT HEALTH PROBLEMS? ☐Yes ☐No

Are you currently under a PHYSICIAN'S CARE ? ☐Yes ☐No
If yes, for what? ____
What MEDICATIONS (including over the counter) do you take? __________________________

____

What SUPPLEMENTS (including herbal) you you take? _______________________________

____

Women: Are you PREGNANT? ☐No ☐Yes, due date: __________________
Do you take BIRTH CONTROL PILLS? ☐Yes ☐No

Do you SMOKE or use OTHER TOBACCO PRODUCTS? ☐Yes ☐No
# of packs per day: _________

✔ CHECK ANY OF THE FOLLOWING CONDITIONS THAT YOU HAVE HAD OR PRESENTLY HAVE:

☐Alcoholism	☐Alzheimer's Disease	☐Anemia
☐Arthritis	☐Artificial Joints or Prosthesis	☐Asthma
☐Cancer (Type __________)	☐Chemotherapy	☐Diabetes
☐Drug Addiction	☐Emphysema	☐Epilepsy
☐Excessive Bleeding	☐Glaucoma	☐Heart Murmur
☐Heart Disease or Attack	☐Heart Surgery	☐Herpes
☐Heart Valve Replacement	☐High Blood Pressure	☐High Cholesterol
☐Hepatitis A (Infectious)	☐Hepatitis B (Serum)	☐Hepatitis C
☐HIV+/AIDS	☐Fever Blisters	☐Kidney Disease
☐Liver Disease	☐Mental Disorders	☐Nervous Disorders
☐Mitral Valve Prolapse	☐Pacemaker	☐**Pre-medicate**
☐Pain in Jaw or Joints	☐Radiation Treatment	☐Rheumatic Fever
☐Rheumatism	☐Seasonal Allergies	☐Seizures
☐Sinus Problems	☐Stomach Ailments	☐Stroke
☐Thyroid Disease	☐Tuberculosis (TB)	☐Ulcers
☐Venereal Disease		

CIRCLE ANY OF THE FOLLOWING THAT YOU HAVE A KNOWN ALLERGY TO or HAVE HAD AN ADVERSE REACTION TO:

Codeine Erythromycin Latex Local Anesthetic
Penicillin Sulfa

Are you aware of being allergic to any other medications or substances? ☐Yes ☐No
If yes, please list all known allergies:____

Do you take any blood thinners (i.e. Coumadin or Plavix) that may need to be discontinued prior to dental treatment?
☐Yes ☐No
Is there any other MEDICAL or DENTAL information that we should be aware of? ☐Yes ☐No
____

YOUR REGULAR PHYSICIAN'S NAME and PHONE NUMBER ____
____

PATIENT DENTAL HISTORY

How Long Since you have seen a dentist? __________
Is your present dental health ☐GOOD ☐FAIR ☐POOR

Are you having any dental problems now? ☐Yes ☐No
Are you afraid or nervous about dental treatment? ☐Yes ☐No
Do your gums BLEED, feel TENDER or IRRITATED? ☐Yes ☐No
Are you UNHAPPY with the APPEARANCE of your teeth? ☐Yes ☐No
Do you have HEADACHES, EARACHES, or NECK PAIN? ☐Yes ☐No
Do you have DISCOLORED teeth that you are unhappy with? ☐Yes ☐No
Would you like your smile to LOOK BETTER or DIFFERENT? ☐Yes ☐No
Do you REGULARLY use DENTAL FLOSS? ☐Yes ☐No
In general, how do you feel about your teeth?____

Appointments– Our office takes pride in the fact that we run on time and try to be as efficient as possible. We expect that our patients will be equally as courteous. If you are late for an appointment, our office will make an effort to be sure that you are seen, if time allows. Otherwise, the appointment will need to be rescheduled. **We request that you give 48 hour notice if you are unable to make your scheduled appointment.** If you fail an appointment or re-schedule a procedure multiple times, our office reserves the right to request that you seek services elsewhere.

FINANCIAL POLICIES

1. **FINANCE CHARGE-** I agree to pay up to 1.5% per month (**18%** Annual Percentage Rate) on any balance over 60 days old.
2. **BILLING CHARGE**- I agree to pay up to **$5** per month for billing costs, if any balance remains beyond 60 days from the date services are rendered.
3. **COLLECTION COSTS**- I agree to pay any **attorney fees, court costs**, and a **35%** Collection Fee if collection by a third party is necessary.
4. **BAD CHECK CHARGE**- I understand that a **$25** charge will be added to my balance if any check is returned for insufficient funds. Further, I agree to pay my total balance by cash or money order with in 10 days check's return to the office of David C. Walden.
5. **RESPONSIBLE PARTY**– The parent/guardian who presents a **minor child** for treatment is responsible for payment of the account, regardless of any court orders stating otherwise, unless written permission to bill another party is presented to our office at the time of service.
6. **INSURANCE**– If I am insured, I realize that the dental office will file my claim as a courtesy to me. I agree to remit payment of my balance in full in the event that my insurance company denies or delays payment after 60 days from when the service is rendered. I also realize that most insurance plans do not cover 100% of the cost of dental treatment. **I acknowledge that I am responsible for any patient portion and agree to pay the estimated amount at the time of service**. I know that this estimate is not a guarantee of payment on the part of my insurance company and that I may be responsible for a different amount than I have been quoted.

The information I have given today is correct to the best of my knowledge. It is my responsibility to **inform** this office of any changes in medical status. I hereby authorize the dental staff to **perform any necessary dental services** with my informed consent that may be needed during diagnosis and treatment. I authorize the **release of any information** including the diagnosis and records rendered to me or my child to **insurance companies and/or other health practitioners**. I authorize and request my insurance company to **pay directly to the dentist** benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services and I agree to pay any amount not covered. **I understand the financial policies** and agree to be **responsible for payment** of all services rendered to me or my dependants.

SIGNATURE of PATIENT or RESPONSIBLE PARTY:

____ Date: _____________