FRESH DENTAL GROUP

PATIENT MEDICAL HEALTH HISTORY

Name: _____ Date of Birth: _____

Primary Physician: _____ Address: _____

Specialist: _____ Date of Last Physical Exam: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Please list any current medications: _____

_____

Do you need to be pre-medicated for dental procedures because of a prosthetic replacement or for another reason? Y N If so, what antibiotic has been prescribed?_____

General Health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Health History	Yes	No	If yes, please explain:
Are you currently under the care of a physician?			
Have you ever been hospitalized or had a major operation?			
Do you take, or have you taken, Phen-fen or Redux?			
Are you on a special diet?			
Do you use tobacco?			
Do you use controlled substances?			
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?			
Have you been treated with radiation or chemotherapy?			
Are you taking blood thinners?			

Are you allergic to any of the following? Please check all that apply:							
Aspirin		Penicillin		Codeine		Acrylic	
Metal		Latex		Sulfa Drugs		Local Anesthetics	
Other: _____							

Women, are you:	Yes	No
Pregnant or trying to become pregnant?		
Nursing?		
Taking oral contraceptives?		

(*Continued below*)

Do you have, or have you had, any of the following? Please check all that apply:										
	Y	N		Y	N		Y	N		Y	N
HEART / BLOOD VESSELS			**NERVOUS SYSTEM**			**DIGESTIVE SYSTEM**			**EYES**		
Rheumatic Fever			Stroke			Hepatitis A, B, or C			Visual change		
Heart Attack / Failure			Frequent Headaches			Jaundice			Glaucoma		
Heart Murmur			Epilepsy or Seizures			Ulcers			**NOSE**		
Heart Pacemaker			Numbness / tingling			**URINARY**			Frequent nosebleeds		
Shortness of breath			Dizzyness / fainting			Kidney disease			Sinus problems		
Congenital Heart Disorder			Psychiatric Care			Venereal disease			**THROAT**		
High Blood Pressure			Shingles			Renal Dialysis			Soreness/hoarseness		
Artificial Heart Valve			**RESPIRATORY**			**BLOOD**			Tonsillitis		
Swelling of the Limbs			Tuberculosis			Sickle Cell Disease			**GENERAL**		
Heart surgery			Emphysema			Anemia			Tire easily, weakness		
Chest Pains			Asthma / hay fever			Blood transfusion			Marked weight change		
Irregular Heartbeat			Persistent cough			Hemophilia			Night sweats		
Other: _____			Difficulty breathing while laying down			Hypoglycemia			Persistent fever		
ENDOCRINE			Sleep apnea			Excessive Bleeding			**OTHER**		
Diabetes			**BONE MUSCLES**			Leukemia			AIDS / HIV Positive		
Family history of diabetes			Arthritis / Gout			**SKIN**			Alzheimer's Disease		
Thyroid disease			Artificial Joint			Eruptions (rash) hives			Anaphylaxis		
Other: _____			Pain in Jaw Joints			Change in skin color			Drug Addiction		
			Osteoporosis						Cancer		
									Chemotherapy		
									Radiation Treatments		
									Tumors or Growths		
									Thyroid Disease		

Reviewed by: _____ Date: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____ _____

Signature of Patient, Parent, or Guardian Date

_____

Print Name

PATIENT DENTAL HEALTH HISTORY

Patient Information

Name: _____ Nickname: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Work: _____ Cell: _____

Sex: ☐ Male ☐ Female ☐ Other: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Date of Birth: _____ SSN: _____ Email: _____
Occupation: _____ Emergency Contact: _____

Dental History

Date of last dental exam: _____ Date of last professional cleaning: _____
Previous Dentist: _____ Phone # _____
Notable dental procedures: _____
Referred by: _____
Reason for visit: _____

I routinely see my dentist every:
☐ 3 months ☐ 6 months ☐ 12 months ☐ Other: _____

How often do you brush your teeth? _____
How often do you floss your teeth? _____
What texture toothbrush do you use? ☐ hard ☐ medium ☐ soft

Have you had, or are you currently experiencing, any of the following? Please check all that apply:							
Bad Breath		Grinding Teeth		Sensitivity to Cold		Jaw Pain	
Sensitive Chewing		Sensitive Biting		Sensitivity to Heat		Loose Teeth	
Broken Teeth		Sores or Lesions		Sensitivity to Sweets		Bleeding Gums	
Discolored Teeth		Abscess		Toothache			

Dental History	Yes	No	If yes, please explain:
Do you have all your teeth? If not, which are missing?			
Do you have oral habits which might affect your oral health (i.e. pipe smoking, playing musical instruments, biting fingernails)?			
Do you avoid chewing on one side of your mouth?			
Have you had complications with past dental treatment?			
Have you had trouble getting numb?			
Have you had reactions to local anesthetic?			
Does food get trapped between your teeth?			
Have you ever whitened or bleached your teeth?			
Do you wear a bite appliance?			
Do you snore or wake up frequently during the night?			

Reviewed by: _____ Date: _____

Consent for Services and Financial Policy

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our changes will be paid by an insurance company.

A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged 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 (6) months from the date of the patient examination.

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 that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suite be instituted hereunder.

I grant permission to you or your assignee, to telephone, email, or text me to discuss this statement or my treatment.

I understand the above information and agree with its contents and agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges.

_____ _____

Signature of Patient, Parent, or Guardian Date

Insurance Authorization

☐ By checking this box,
I authorize my insurance company to pay the dentist all benefits rendered.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the dentist or dental entity.

_____ _____

Signature of Patient, Parent, or Guardian Date

Missed Appointments / Late Cancellations Policy

Thank you for selecting FResh Dental Group for your dental needs. We would like to take this opportunity to inform you of our practice's Missed Appointments / Late Cancellations Policy.

Missed appointments represent a cost to us, to you, and to other patients who could have been seen in the time set aside for you. Cancellations are requested 24 hours prior to the appointment. We reserve the right to charge for missed appointments or appointments not cancelled within 24 hours. Effective June 1, 2019, the charge for missed appointments is $35 for a single missed appointment / late cancellation. Excessive abuse of scheduled appointments may result in discharge from the practice.

If you have any questions about this policy, do not hesitate to ask.

_____
Cardholder Name

_____
Patient Name

_____
Email Address

I have read the above and understand that all missed appointment / late cancellation fees which I incur at FResh Dental Group are ultimately my responsibility. I authorize FResh Dental Group to process payments for missed appointment / late cancellation fees using the credit card information which I have provided.

_____ _____
Signature of Cardholder Date