



## PATIENT HISTORY FORM

Name \_\_\_\_\_ Legal Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Sex \_\_\_\_\_

The following information is to be reviewed by the doctor and staff in the strictest of confidence. It is important that you complete this medical history form in its entirety so that we may accurately diagnose and treat you, according to your general health and wellbeing.

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Zip \_\_\_\_\_ Phone \_\_\_\_\_ E-mail \_\_\_\_\_

Emergency contact (not living with you) \_\_\_\_\_ Phone \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Wk Phone \_\_\_\_\_

Spouse's Name (or parent if child) \_\_\_\_\_

Spouse (or parent) employed by \_\_\_\_\_ Occupation \_\_\_\_\_

If you are a new patient, whom can we thank for referring you? \_\_\_\_\_

## GENERAL MEDICAL HISTORY

Please mark the box only if **YES**:

- Are you in good health?
- Are you presently under the care of a physician?

If yes, what is the condition or nature of the illness: \_\_\_\_\_  
\_\_\_\_\_

Name of Physician \_\_\_\_\_

Date of last Physical exam \_\_\_\_\_

Have you been hospitalized or had a major illness in the last 5 years? If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

- Do you have any allergies to anesthetics?
- Allergies to medications or drugs? If so please name them: \_\_\_\_\_  
\_\_\_\_\_

- Are you currently taking any medications? If yes please list: \_\_\_\_\_  
\_\_\_\_\_

Are you happy with your oral health?  
Yes No

Are you happy with the appearance of your teeth, gums, and/or smile? Yes No

Would you like to discuss enhancing the appearance of your smile? Yes No

Would you like to discuss how to make your teeth WHITE? Yes No

What don't you like about your smile?  
\_\_\_\_\_  
\_\_\_\_\_

How often do you brush your teeth? \_\_\_\_\_

How often do you floss? \_\_\_\_\_

When was your last dental cleaning? \_\_\_\_\_

When was your last dental exam? \_\_\_\_\_

For women ONLY:

- Is there a possibility that you may be pregnant? If so expected due date \_\_\_\_\_
- Are you currently nursing?
- Are you on birth control pills?

Have you ever had or been treated for any of the following conditions or diseases?

- AIDS/HIV
- Anemia/low iron
- Arthritis/Swollen joints
- Asthma
- Bleeding disorder
- Chemotherapy
- Circulatory problems
- Diabetes
- Fainting spells
- GERD/ Acid Reflux
- Glaucoma
- Heart Disease/ Trouble
- Heart Murmur
- Hepatitis
- Herpes
- High blood pressure
- Immune system disorder
- Joint replacement
- Kidney Disease
- Liver Disorder
- Low blood pressure
- Mitral Valve Prolapse
- Mononucleosis
- Nervous/Neurological disorder
- Pacemaker
- Psychiatric Treatment
- Radiation Treatment
- Respiratory illnesses
- Rheumatic fever
- Seizures
- Sexually Transmitted Disease
- Shortness of breath
- Sinus problems
- Stroke
- Swollen glands
- Thyroid problems
- Tuberculosis
- Tumor Growth/ Cancer
- Ulcers

Please describe any current medical treatments, surgeries, or other medical or dental information that may affect your dental treatment:

\_\_\_\_\_  
\_\_\_\_\_

- Are you on birth control pills?
- Do you have pain/clicking when opening or closing your jaw?
- Have you ever had TMJ treatment?
- Do you have any discomfort in your mouth presently?
- Are your teeth sensitive to hot or cold?
- Are your teeth sensitive to sweets?
- Have you ever had your teeth straightened?
- Have you ever been diagnosed as having periodontal disease?
- Do you grind or clench your teeth? Do your gums bleed when you brush your teeth?
- Do you get frequent blisters on your lips or mouth?
- Are you a thumb sucker? Nail biter? Mouth breather? Circle which, if yes.
- Are you aware of any swelling or lump in your mouth?
- Have you ever been told you need to be medicated with antibiotics before dental appointments?
- Do you have dental fear/anxiety?
- Have you ever had a problem with local anesthesia?
- Do you have any artificial joints (hips, knees, etc) or valves (heart)? Please List:

\_\_\_\_\_  
\_\_\_\_\_

Do you use tobacco products? If so, how much and what form? \_\_\_\_\_

\_\_\_\_\_

The information given about my health history in this form is to the best of my knowledge. I hereby give my consent to perform necessary diagnostic tests (including x-rays) and evaluation of my dental health. Patient, parent, or guardian:

Signature: \_\_\_\_\_  
Date: \_\_\_\_\_

.....

Medical review: I have reviewed this medical and dental history, and have added any changes since my last visit.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## PAYMENT POLICY

Our responsibility to you is to recommend *Full Care Dentistry*, just as we would for ourselves or a member of our family. If you have dental insurance, please keep in mind that the insurance company's priority is to pay the least amount on the cheapest procedure, regardless of what is recommended by a licensed dentist for your optimum dental health. As a courtesy to you, we are happy to provide information and bill your dental insurance after your portion has been paid; however, please keep in mind that your insurance contract is between the insurance company and you, not our office. If we know that some of a procedure will be covered, but are unsure on what percent the insurance will pay, we will ask that you pay 30% of that day's total. If the insurance provides more than 70% of that total, a credit will be placed on your account or a check will be made out to you. Ultimately, any remaining balance after insurance has paid is your responsibility. Fortunately, we now have several options to aid your payment process, as listed below:

**Cash, Check or Credit Card** (including Visa, MasterCard, Discover or American Express): may be paid in advance according to the table below or per visit directly following procedure.

Payment in advance on treatment plan over \$1000.00	- 10% discount
Payment in advance on treatment plan under \$1000.00	- 7% discount
Payment in full at time of service	- 5% discount

**Care Credit:** A great revolving credit plan providing 1 year no interest or an extended care plan. This plan is aimed to help aid you with medical/dental costs, and can be used in any medical, optical, veterinary or other medical office in their nationwide network. They have one of the highest approval ratings in the country.

**Capital One Dental Fee Plan:** A fixed rate Credit Card with low monthly fees, which is geared specifically to your dental needs.

We consider these our in house financing plans. We do not take monthly payments. Payment is due at time of service. Please feel free to ask a staff member for more information and an application form regarding these plans.

Please complete the following if applicable:

<b>Primary Insurance</b>	<b>Secondary Insurance</b>
Company name _____	Company name _____
Group member _____	Group member _____
Group number _____	Group number _____
Member number _____	Member number _____
Member's SS# _____	Member's SS# _____

I hereby give Dr. Bouzis and staff permission to bill my insurance carrier, if available, for any procedures performed. I realize that I am ultimately responsible for any and all procedures charged to my account, and fully understand the policy listed above.

Patient Signature (parent or guardian if minor) \_\_\_\_\_

Date: \_\_\_\_\_