PLATTEVILLE FAMILY DENTISTRY™

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HEALTH HISTORY

Patient Name: _____ **Birth Date: _____**

I. CIRCLE APPROPRIATE ANSWER

1. Yes No Is your general health good?
2. Yes No Has there been a change to your health within the last year?
3. Yes No Have you been hospitalized or had a serious illness in the last three years?
   If YES, why? _____
4. Yes No Are you being treated by a physician now? For what? _____
   _____
   Date of last medical exam _____ Date of last professional dental cleaning _____
5. Yes No Have you had problems with prior dental treatment?
6. Yes No Are you in pain now? If so, rate it on a scale of 1-10 (10 being the worst) _____

II. HAVE YOU EXPERIENCED

7. Yes No Chest pain (angina)?
8. Yes No Swollen ankles?
9. Yes No Recent weight loss, fever, night sweats?
10. Yes No Persistent cough, coughing up blood?
11. Yes No Bleeding problems, bruising easily?
12. Yes No Sinus problems?
13. Yes No Difficulty swallowing
14. Yes No Diarrhea, constipation, blood in stools?
15. Yes No Frequent vomiting, nausea?
16. Yes No Difficulty urinating, blood in urine?
17. Yes No Dizziness?
18. Yes No Ringing in ears?
19. Yes No Headaches?
20. Yes No Fainting spells?
21. Yes No Blurred vision?
22. Yes No Seizures?
23. Yes No Excessive thirst?
24. Yes No Frequent urination?
25. Yes No Dry mouth?
26. Yes No Jaundice?
27. Yes No Joint pain/stiffness?

III. DO YOU HAVE OR HAVE YOU HAD

28. Yes No Heart disease?
29. Yes No Swollen ankles?
30. Yes No Shortness of breath?
31. Yes No Rheumatic fever?
32. Yes No Stroke, hardening of arteries?
33. Yes No High blood pressure?
34. Yes No Asthma, TB, emphysema, other lung disease?
35. Yes No Hepatitis, other liver disease?
36. Yes No Stomach problems, ulcers?
    No Jaw pain/soreness?
37. Yes No Family history of diabetes, heart problems,
38. Yes No Tumors.
39. Yes No AIDS?, HIV+
40. Yes No Tumors, cancer?
41. Yes No Arthritis, rheumatism?
42. Yes No Eye diseases?
43. Yes No Skin diseases?
44. Yes No Anemia?
45. Yes No Cold sores in mouth (oral herpes)
46. Yes No Kidney, bladder disease?
47. Yes No Thyroid, adrenal disease?
48. Yes No Diabetes?

IV. DO YOU HAVE OR HAVE YOU HAD

49. Yes No Psychiatric care?
50. Yes No Radiation treatments?
51. Yes No Chemotherapy?
52. Yes No Prosthetic heart valve?
53. Yes No Artificial joint?
54. Yes No Hospitalizations?
55. Yes No Blood transfusions?
56. Yes No Surgeries?
57. Yes No Pacemaker?

V. DO YOU USE OR HAVE YOU USED

58. Yes No Recreational drugs?
59. Yes No Drugs, medications, over-the-counter medicines (including aspirin, natural remedies)
60. Yes No Bisphosphonates – generic and brand names include but are not limited to: *alendronate (Fosamax®), alendronate/cholecalciferol (Fosamax® D), risedronate (Actonel®), ibandronate (Boniva®), and zoledronic acid (Reclast®). Denosumab (Prolia®).*
61. Yes No Tobacco, if yes, which form (eg, smoke, chew)_____
62. Yes No Alcohol – more than two drinks per day?

Please list all current medications:

_____

_____

VI. HAVE YOU EXPERIENCED AN ALLERGIC OR AN ADVERSE REACTION TO THE FOLLOWING

63. Yes No Penicillin
64. Yes No Latex
65. Yes No Sulfa
66. Yes No Codeine (Tylenol III)
67. Yes No Hydrocodone ("Vicodin" / "Lortab")
68. Yes No Foods, if yes, please list _____
69. Yes No Other, if yes, please list _____

VII. WOMEN ONLY

70. Yes No Are you, or could you be pregnant or nursing?
71. Yes No Taking birth control pills?

VIII. ALL PATIENTS

72. Yes No Do you have, or have you had any other diseases or medical problems NOT listed on this form?

If so, please explain _____

_____

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health, and/or medication.

Patient's signature _____ Date _____

PLATTEVILLE FAMILY DENTISTRY

Appointment Policy

Our fees are lower than most dentists in this area, and we would like to keep it that way! You can help us do so by preventing costly, last minute gaps in our schedule. We reserve time exclusively for each patient. If you absolutely must reschedule, we require a **minimum notification of 24 hours** prior to your appointment. We can then make your reserved time available for other patients. To notify us of any change, please call our office during business hours.

Thank you for choosing our practice to serve your dental health needs. We are dedicated to providing you with quality, comfortable, and affordable care.

Patient's signature _____ Date _____

Printed Name _____

PLATTEVILLE FAMILY DENTISTRY

Financial Agreement

- For my convenience, Platteville Family Dentistry may release my information to my insurance company, and receive payment directly from them.
- I understand that if I begin major treatment that involves lab work, I will be responsible for the fee at that time.
- If sent to collections, I agree to pay all related fees and court costs.
- Every effort will be made to help me with my insurance, but if they do not pay as expected, I will still be responsible.
- I agree to pay finance charges of 1.5% per month (18% APR) on any balance 90 days past due.
- I will pay a fee for appointments broken without 24 hours notice.
- Treatment plans may change and I will be responsible for the work actually done.

Patient's signature _____ Date _____

Printed Name _____

PLATTEVILLE FAMILY DENTISTRY™

Notice of Privacy Policies

I have had full opportunity to read and consider the contents of the Notice of Privacy Practices. I understand that I am giving my permission to your use and disclosure of my protected health information in order to carry out treatment, payment activities, and healthcare operations. I also understand that I have the right to revoke permission.

The Notice of Privacy Practices can be found on our website at www.PlattevilleFamilyDentistry.com, or can be found in our coffee station:

Patient's signature _____ Date _____

Printed Name _____

PLATTEVILLE FAMILY DENTISTRY

PATIENT INFORMATION FORM

Name _____ _____ ____ _____
Last First M.I. Preferred

Birthdate (MM/DD/YY) _____ SS# _____

Gender___M ___F **Marital Status** (Circle One): Married / Single / Divorced

Driver License State:_____ Driver License Number:_____

Home Address:
Street _____ City_____
State _____ Zip Code _____

Phone Numbers:
Cell _____,Cell Phone Carrier (i.e. Sprint/Verizon) _____
Home _____ Work _____

E-mail: _____

If over 21 years old, are you a full time student? ____Yes ____No

School Name _____City _____ State_____

Parent / Legal Guardian Information (If patient under 21 years of age)

Name _____ _____ ____ _____
Last First M.I. Preferred

Gender___M ___F Relationship to Patient_____

Driver License State:_____ Driver License Number:_____

Birthdate (MM/DD/YY) _____ SS# _____
Gender___M ___F **Marital Status** (Circle One): Married / Single / Divorced

Home Address

____Check here if address same as patient. Otherwise, please list your mailing address.

Street _____ City_____
State _____ Zip Code _____

Phone Numbers:
Cell _____,Cell Phone Carrier (i.e. Sprint/Verizon) _____
Home _____ Work _____

E-mail: _____

Dental Insurance Information

Primary Insurance Company _____

Relationship to Subscriber (Circle One) Self / Spouse or Life Partner / Child

Insurance Company Phone# _____

Subscriber Name _____ _____ _____
Last First M.I.

Subscriber Birthdate (MM/DD/YY) _____

Subscriber I.D# or SS#_____

Employer _____ Group Name _____Group#_____

Secondary Insurance Company _____

Relationship to Subscriber (Circle One) Self / Spouse or Life Partner / Child

Insurance Company Phone# _____

Subscriber Name _____ _____ _____
Last First M.I.

Subscriber Birthdate (MM/DD/YY) _____

Subscriber I.D# or SS#_____

Employer _____ Group Name _____Group#_____

_____ _____
Signature ***Date***