Health History Form

ADA American Dental Association®
America's leading advocate for oral health

Email: Today's Date:

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: *Last* *First* *Middle*
Home Phone: *Include area code* ( )
Business/Cell Phone: *Include area code* ( )
Address: *Mailing address*
City: State: Zip:
Occupation:
Height: Weight: Date of Birth: Sex: M F
SS# or Patient ID: Emergency Contact:
Relationship: Home Phone: *Include area code* ( ) Cell Phone: *Include area code* ( )
If you are completing this form for another person, what is your relationship to that person?
Your Name *Relationship*

Do you have any of the following diseases or problems: *(Check DK if you Don't Know the answer to the the question)*	**Yes**	**No**	**DK**
Active Tuberculosis	☐	☐	☐
Persistent cough greater than a 3 week duration	☐	☐	☐
Cough that produces blood	☐	☐	☐
Been exposed to anyone with tuberculosis	☐	☐	☐

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Dental Information *For the following questions, please mark (X) your responses to the following questions.*

	Yes	**No**	**DK**
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐
Do you drink bottled or filtered water?	☐	☐	☐

If yes, how often? *Circle one:* DAILY / WEEKLY / OCCASIONALLY

Are you currently experiencing dental pain or discomfort?	☐	☐	☐

	Yes	**No**	**DK**
Do you have earaches or neck pains?	☐	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Do you brux or grind your teeth?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Do you participate in active recreational activities?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐

Date of your last dental exam:
What was done at that time?
Date of last dental x-rays:

What is the reason for your dental visit today?

How do you feel about your smile?

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

	Yes	**No**	**DK**
Are you now under the care of a physician?	☐	☐	☐

Physician Name: Phone: *Include area code* ( )
Address/City/State/Zip:

Are you in good health?	☐	☐	☐
Has there been any change in your general health within the past year?	☐	☐	☐

If yes, what condition is being treated?
Date of last physical exam:

	Yes	**No**	**DK**
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐	☐

If yes, what was the illness or problem?

Are you taking or have you recently taken any prescription or over the counter medicine(s)?	☐	☐	☐

If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements:

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

(Check DK if you Don't Know the answer to the question)

	Yes	No	DK
Do you wear contact lenses?	☐	☐	☐
Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	☐	☐	☐
Date: _____ If yes, have you had any complications? _____			
Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax®, Actonel®, Atelvia, Boniva®, Reclast, Prolia) for osteoporosis or Paget's disease?	☐	☐	☐
Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia®, Zometa®, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?	☐	☐	☐
Date Treatment began: _____			

	Yes	No	DK
Do you use controlled substances (drugs)?	☐	☐	☐
Do you use tobacco (smoking, snuff, chew, bidis)?	☐	☐	☐
If so, how interested are you in stopping? *Circle one:* VERY / SOMEWHAT / NOT INTERESTED			
Do you drink alcoholic beverages?	☐	☐	☐
If yes, how much alcohol did you drink in the last 24 hours? _____			
If yes, how much do you typically drink i n a week? _____			
WOMEN ONLY Are you:			
Pregnant?	☐	☐	☐
Number of weeks: _____			
Taking birth control pills or hormonal replacement?	☐	☐	☐
Nursing?	☐	☐	☐

Allergies. Are you allergic to or have you had a reaction to:
To all **yes** responses, specify type of reaction.

	Yes	No	DK
Local anesthetics _____	☐	☐	☐
Aspirin _____	☐	☐	☐
Penicillin or other antibiotics _____	☐	☐	☐
Barbiturates, sedatives, or sleeping pills _____	☐	☐	☐
Sulfa drugs _____	☐	☐	☐
Codeine or other narcotics _____	☐	☐	☐
Metals _____	☐	☐	☐
Latex (rubber) _____	☐	☐	☐
Iodine _____	☐	☐	☐
Hay fever/seasonal _____	☐	☐	☐
Animals _____	☐	☐	☐
Food _____	☐	☐	☐
Other _____	☐	☐	☐

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No	DK
Artificial (prosthetic) heart valve	☐	☐	☐
Previous infective endocarditis	☐	☐	☐
Damaged valves in transplanted heart	☐	☐	☐
Congenital heart disease (CHD)			
Unrepaired, cyanotic CHD	☐	☐	☐
Repaired (completely) in last 6 months	☐	☐	☐
Repaired CHD with residual defects	☐	☐	☐

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

	Yes	No	DK
Cardiovascular disease	☐	☐	☐
Angina	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Congestive heart failure	☐	☐	☐
Damaged heart valves	☐	☐	☐
Heart attack	☐	☐	☐
Heart murmur	☐	☐	☐
Low blood pressure	☐	☐	☐
High blood pressure	☐	☐	☐
Other congenital heart defects	☐	☐	☐
Mitral valve prolapse	☐	☐	☐
Pacemaker	☐	☐	☐
Rheumatic fever	☐	☐	☐
Rheumatic heart disease	☐	☐	☐
Abnormal bleeding	☐	☐	☐
Anemia	☐	☐	☐
Blood transfusion If yes, date: _____	☐	☐	☐
Hemophilia	☐	☐	☐
AIDS or HIV infection	☐	☐	☐
Arthritis	☐	☐	☐

	Yes	No	DK
Autoimmune disease	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Systemic lupus erythematosus	☐	☐	☐
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐
Tuberculosis	☐	☐	☐
Cancer/Chemotherapy/ Radiation Treatment	☐	☐	☐
Chest pain upon exertion	☐	☐	☐
Chronic pain	☐	☐	☐
Diabetes Type I or II	☐	☐	☐
Eating disorder	☐	☐	☐
Malnutrition	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
G.E. Reflux/persistent heartburn	☐	☐	☐
Ulcers	☐	☐	☐
Thyroid problems	☐	☐	☐
Stroke	☐	☐	☐

	Yes	No	DK
Glaucoma	☐	☐	☐
Hepatitis, jaundice or liver disease	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Neurological disorders If yes, specify: _____	☐	☐	☐
Sleep disorder	☐	☐	☐
Do you snore?	☐	☐	☐
Mental health disorders Specify: _____	☐	☐	☐
Recurrent Infections Type of infection: _____	☐	☐	☐
Kidney problems	☐	☐	☐
Night sweats	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistent swollen glands in neck	☐	☐	☐
Severe headaches/ migraines	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
Excessive urination	☐	☐	☐

	Yes	No	DK
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	☐	☐	☐

Name of physician or dentist making recommendation:

Phone: *Include area code*
( )

	Yes	No	DK
Do you have any disease, condition, or problem not listed above that you think I should know about?	☐	☐	☐

Please explain:

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: Date:

Signature of Dentist: Date:

FOR COMPLETION BY DENTIST

Comments:

PHYLLIS PENDERGRAST, DMD, PC
HANNAH SUMMERFELT, DMD

3539 Thomas Street
Fairbanks, Alaska 99709
907-452-7041
ppendergrast@gci.net

Dental Insurance Information:

Do you have dental insurance: _____yes _____no

PRIMARY DENTAL INSURANCE:

Policy holder name (if different than patient):_____

Policy holder date of birth:_____

Member iD or subscriber iD:_____

Policy holder employment:_____

Dental Insurance Company:_____

Group or plan number of policy:_____

If you have another dental insurance company besides the one listed above, please complete the following:

SECONDARY DENTAL INSURANCE:

Policy holder name (if different than patient):_____

Policy holder date of birth:_____

Member iD or subscriber iD:_____

Policy holder employment:_____

Dental Insurance Company:_____

Group or plan number of policy:_____

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My signature below confirms that I understand that no dental treatment is completely risk free and that my dentist will take reasonable steps to limit any complications of my treatment to provide competent dentistry with comfort and care.

I understand that some after-treatment effects and complications tend to occur with regularity.

For routine fillings, dental cleanings, prescription of medications, I understand this includes but is not limited to: temporary soreness, temperature sensitivity, unusual reaction/allergy to medications given or prescribed. Also, medications have common side effects that are listed by the manufacturer. Further, if I am taking other medications, my dental medications could have an adverse interaction and I need to fully disclose all of my medications to the dentist and pharmacist. This includes herbal supplements.

For the administration of local anesthetic, I understand that for many treatments and procedures I will be given a local anesthetic injection and that in certain percentage of cases patients have had an allergic reaction to the anesthetic, or temporary or permanent injury to nerves and/or blood vessels from the injection. For oral surgery, I understand that there is always a risk of a post-operative infection, nerve damage, and iatrogenic injury. In rare cases, the complications from surgery can be permanent, disabling or even cause death. I understand that the injection area(s) may be uncomfortable following treatment and that my jaw may be stiff and sore from holding my mouth open during treatment.

I understand that all treatments and procedures have a risk of separation or breakage of dental instruments which may become lodges in a gum or other soft tissues or aspirated. Should I experience any of these or other conditions during or following a treatment, I will contact my dentist as soon as possible.

I understand that the practice of dentistry is not an exact science and my dentist offers no guarantees or assurance as to the outcome or result of treatment or surgery.

I have the right to ask my dentist for more information if I have any concerns about my procedures and the possible side effects or complications, and I promise to use that t right to its fullest extent if for any reason I feel I am not fully informed about my procedures, the risks of the procedures, and my alternatives to the procedures.

_____ _____

Printed name patient/guardian Date

_____

Signature of patient/guardian

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FINANCIAL AGREEMENT

We thank you for choosing our office to provide your dental care. Our philosophy in serving our patients is to be informative, honest and forthright. This financial agreement is indicative of our respect for your right to know ahead of time what our office financial policies are. If you have any questions or concerns about our policies please do not hesitate to ask our financial coordinator.

Dental Benefits:

Your dental insurance is a benefit your employer has contracted with the insurance companies. As a courtesy we will file your claims and accept assignment of dental benefits provided you agree to the following:

*You provide the office with your insurance card with all the necessary information needed to verify your benefits and coverage under that policy.

*You understand that your insurance policy is a contract solely between your employer and the insurance company and we are not held accountable nor responsible for what your policy covers or does not cover.

*You understand that our office is an out of network provider/non PPO and the difference, if any, in coverage will be made known to you to the best of our knowledge.

*Our office will make known to you to the best of our knowledge, your benefit plan, benefit limitations and estimated out of pocket expenses; please note this is not a guarantee for what the insurance will actually pay-out and if any questions regarding your plan it is your responsibility to contact your insurance company for those answers.

*At the time of service, you are responsible for any difference from provider fee and the insurance “usual and customary” as well as the known deductible and estimated co-pay.

*You understand that at the time of service we estimate to the best of our knowledge your co-pay, but make it known that there may be an addition balance after the insurance has made their pay out for that service and this balance will be your responsibility.

*You understand that not all services we provide may not be a covered benefit and you also understand that this may not be known until after the claim has been processed.

*You understand that any and all fees that are not covered by your policy are fully your responsibility regardless of the reason for non-payment.

Payment Policy:

*****AT THE TIME OF SERVICE ALL ESTIMATED CO-PAYS, KNOWN DEDUCTIBLES AND ANY BALANCE ON ACCOUNT ARE DUE IN FULL*****

*We accept all major credit cards, debit cards, personal checks, bank checks, money orders and cash.

*After your dental insurance has made payment on your service, if there is any remaining balance due, you will be sent a statement and full payment will be expected no more than 30 days past date sent. You can send in your payment or call your payment into the office.

Patients Without Insurance Coverage:

*Payment in full will be expected at the time of service.

Minor Patients:

*The parent or guardian accompanying the minor will be responsible for signing this financial agreement.

*The parent or guardian accompanying the minor is responsible for full payment at the time of service.

*In the case of divorced or separated parents, the office is not to be the advocate of designating the responsible party or collecting from the other parent. The office protocol is to be a non-involved party in the case of divorce and separated households and will proceed with any necessary treatment that is in the best interest of the minor. Financial responsibility will be with the parent or guardian accompanying the minor at the time of service.

Returned checks:

*There is a $25 return check fee that will be applied to your account.

Overdue Balances:

*Finance charges may be applied to all balances not paid within 30 days of the monthly billing date.

*Any account with a balance 90 days past due may be subject to being sent to collections. At that time, you will be responsible for any and all fees incurred in the collections process which includes, but is not limited to, an interest rate of 10.5% that will be applied to the unpaid balance, any necessary attorney fees, court fees and any other fees associated with the collection of your debt.

We understand temporary financial problems may affect timely payments. In these situations, we encourage you to communicate with the financial coordinator immediately to discuss the possible options in assistance in the management of your account.

Broken and Missed Appointments:

Broken, missed and late cancelled appointments prevent others from receiving the dental care they deserve. We take them seriously and ask you do the same. Our providers are here to best serve you and their time is valued and should be respected. Please be respectful and inform our office with plenty advance notice if an appointment needs to be changed.

*Office policy is we ask you to notify the office as soon as you can if any changes or cancellations need to happen with your appointments. Necessary required time limitations to make these changes is within at least a 24 hour notice to avoid any potential cancellation/no show fees.

*Any appointments not cancelled within this 24 hour time frame will be considered as a broken appointment and will be subject to a $75 fee that will be applied to your account.

*Appointments missed without any notification may be subject to at least a $75 fee up to the hourly fee for the amount of time of the appointment for that scheduled provider. This fee will be applied to your account.

*If there is an on-going history of broken or missed appointments then we reserve the right to dismiss you from the practice.

I hereby authorize my dental treatment and agree to this financial agreement outlined herein. I have read and fully understand the entirety of this financial agreement and will abide by the office protocol of Drs. Phyllis Pendergrast DMD PC and Hannah Summerfelt DMD. I understand that all and any fees and/or balances that may accrue with my dental care within this office are my full responsibility. I assume full financial responsibility for all services within this office here on forward.

_____ _____

Printed name patient/guardian Date

_____

Signature of patient/guardian

PHYLLIS PENDERGRAST, DMD. PC
HANNAH SUMMERFELT, DMD

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HIPAA Release and Consent Form

I understand and acknowledge that any person's over the age of 18 is solely responsible for their dental records and account. I also understand no individual(s) will be given access to my dental records, account information, or appointment status without my specific written permission. Dr. Phyllis Pendergrast D.M.D, PC office will not speak with any individual(s)regarding account information, or permit other individual(s) to schedule appointments, or release any dental information to them without my written consent in accordance with this document.

I,_____, WISH TO grant the following individual(s) access to my dental record, information and appointments; which may include, but not limited to financial, treatment plan and/or appointment scheduling. Please print name of individual(s) and indicate relationship to you that you wish to grant said authorization.

Name _____Relation:_____

Name _____Relation:_____

Name _____Relation:_____

Name _____Relation:_____

Name _____Relation:_____

Patient Signature _____

Patient Printed Name _____

Date_____

Phyllis Pendergrast D.M.D, PC
October 22, 2015