Patient Information, Medical & Dental History

Welcome! So that we may provide you with the best possible care, please complete both sides of this medical/dental history form. All information is completely confidential.

PATIENT INFORMATION

Name_____ [ ] Male [ ] Female Today's Date_____
First *MI* *Last*

How do you wish to be addressed by our staff? _____ Date of Birth____/____/____

Whom may we thank for referring you? _____

SSN # _____ Email Address_____

Mailing Address _____ City _____ State _____ Zip _____

Home # _____ Cell #_____ Work #_____

Do you prefer appointment reminders by: [ ] Email [ ] Phone [ ] Text [ ] All forms/No preference

Do you prefer to receive calls from our office at: [ ] Home [ ] Cell [ ] Work [ ] All forms/No preference

Are you: [ ] Minor [ ] Married [ ] Single [ ] Divorced [ ] Widowed [ ] Separated

Employer _____ Occupation _____

Spouse's Name _____ Date of Birth____/____/____

Spouse's Employer _____ Is the patient a full-time student? [ ] Yes [ ] No

RESPONSIBLE PARTY (if different than patient)

Name_____ Date of Birth____/____/____
First *MI* *Last*

Mailing Address _____ City _____ State _____ Zip _____

Home # _____ Cell #_____ Work #_____

SSN # _____ Relationship to Patient _____

INSURANCE INFORMATION

Subscriber's Name _____ Relationship to Patient _____

Mailing Address _____ City _____ State _____ Zip _____

Date of Birth ____/____/____ SSN # _____ Employer _____

Insurance Company _____ Group # _____ Effective Date ____/____/____

Do you have additional Dental Insurance? [ ] Yes [ ] No
If yes, please complete the following:

Subscriber's Name _____ Relationship to Patient _____

Mailing Address _____ City _____ State _____ Zip _____

Date of Birth ____/____/____ SSN # _____ Employer _____

Insurance Company _____ Group # _____ Effective Date ____/____/____

DENTAL HISTORY – PLEASE FILL OUT TO THE BEST OF YOUR ABILITY

Previous Dentist's Name _____ Phone # _____

Date of last dental visit ____/____/____ How often do you have dental cleanings / exams? _____

How often do you brush your teeth? _____ How often do you floss? _____

Do you have any dental problems now? [ ] Yes [ ] No If yes, explain: _____

MEDICAL HISTORY

[ ] Yes [ ] No Do you have a personal physician? *If yes, who:* _____

[ ] Yes [ ] No Do you go for yearly check-ups?

[ ] Yes [ ] No Have you had surgery or been hospitalized in the last two years?
If yes, why: _____

[ ] Yes [ ] No Have you taken any medications for Osteoporosis that contain bisphosphonates, like Fosamax?
If yes, what: _____

[ ] Yes [ ] No Are you on a special diet? *If yes, what:* _____

[ ] Yes [ ] No Do you have a family history of Diabetes?

[ ] Yes [ ] No Do you have a family history of Periodontal Gum Disease?

[ ] Yes [ ] No Do you use tobacco products? *If yes, what:* _____

[ ] Yes [ ] No Do you use controlled substances? *If yes, what:* _____

[ ] Yes [ ] No Do you need to pre-medicate with antibiotics prior to dental procedures? *If yes, what:* _____

[ ] Yes [ ] No Do you have or have you had cancer? *If yes, what kind:* _____

[ ] Yes [ ] No Have you had chemotherapy treatment? *If yes, when:* _____

[ ] Yes [ ] No Have you had radiation treatment? *If yes, when:* _____

Women, are you:

[ ] Pregnant or trying to get pregnant? [ ] Nursing? [ ] Taking oral contraceptives? [ ] Taking hormone replacement?

Are you allergic to any of the following?

[ ] Aspirin [ ] Metal [ ] Dairy Products [ ] Latex [ ] Sulfa Drugs [ ] Penicillin [ ] Acrylic

[ ] Other Antibiotics [ ] Codeine [ ] Local Anesthetics [ ] Other: _____

Do you currently have, or have you had, any of the following?

[ ] Yes [ ] No A-Fib / Irregular Heartbeat
[ ] Yes [ ] No Alzheimer's Disease
[ ] Yes [ ] No Anxiety
[ ] Yes [ ] No Blood Disease / Transfusion
[ ] Yes [ ] No Epilepsy / Seizures
[ ] Yes [ ] No Fainting Spells / Dizziness
[ ] Yes [ ] No Heart Pacemaker
[ ] Yes [ ] No High / Low Blood Pressure
[ ] Yes [ ] No Liver Disease
[ ] Yes [ ] No Pre-Diabetes / High Blood Sugar
[ ] Yes [ ] No Sinus Trouble
[ ] Yes [ ] No Thyroid Disease
[ ] Yes [ ] No AIDS / HIV Positive
[ ] Yes [ ] No Anaphylaxis
[ ] Yes [ ] No Arthritis / Gout
[ ] Yes [ ] No Congenital Heart Disorder
[ ] Yes [ ] No Excessive Dry Mouth
[ ] Yes [ ] No Frequent Cough
[ ] Yes [ ] No Heart Stents
[ ] Yes [ ] No High Cholesterol
[ ] Yes [ ] No Lung Disease
[ ] Yes [ ] No Psychiatric Care
[ ] Yes [ ] No Sleep Apnea / CPAP
[ ] Yes [ ] No Tuberculosis
[ ] Yes [ ] No Acid Reflux / Heartburn
[ ] Yes [ ] No Anemia
[ ] Yes [ ] No Asthma
[ ] Yes [ ] No Diabetes
[ ] Yes [ ] No Excessive Snoring
[ ] Yes [ ] No Frequent Headaches
[ ] Yes [ ] No Heart Trouble / Disease
[ ] Yes [ ] No Hypoglycemia
[ ] Yes [ ] No Osteoporosis
[ ] Yes [ ] No Recent Weight Loss
[ ] Yes [ ] No Stomach / Intestinal Disease
[ ] Yes [ ] No Ulcers
[ ] Yes [ ] No Alcoholism / Drug Addiction

[ ] Yes [ ] No Angina / Chest Pains
[ ] Yes [ ] No Autoimmune Disease
[ ] Yes [ ] No Eating Disorder
[ ] Yes [ ] No Excessive Thirst
[ ] Yes [ ] No Glaucoma / Eye Disease
[ ] Yes [ ] No Herpes / Cold Sores / Fever Blisters
[ ] Yes [ ] No Kidney Disease
[ ] Yes [ ] No Pain in Jaw Joints / TMJ
[ ] Yes [ ] No Scarlet Fever
[ ] Yes [ ] No Stroke

[ ] Yes [ ] No Orthodontic Treatment

If so, when? _____

[ ] Yes [ ] No Popping or Cracking of the Jaw
[ ] Yes [ ] No Clenching or Grinding of Teeth
[ ] Yes [ ] No Occlusal Guard / Bite Splint

If yes to the following, please explain:

[ ] Yes [ ] No Artificial Heart Valve
_____
[ ] Yes [ ] No Heart Attack / Failure
_____
[ ] Yes [ ] No Heart Murmur
_____
[ ] Yes [ ] No Mitral Valve Prolapse
_____
[ ] Yes [ ] No Rheumatic Fever
_____
[ ] Yes [ ] No Artificial Joint
_____
[ ] Yes [ ] No Hepatitis A, B, or C
_____

Have you ever had any serious illness not listed? [ ] Y [ ] N

_____
_____

Please list any medications that you are currently taking:

_____
_____

GENERAL CONSENT TO DIAGNOSE AND TREAT

The undersigned hereby authorizes Maria C. Hoekstra, DDS, PC to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the undersigned patient's dental condition and needs. I authorize Maria C. Hoekstra, DDS, PC to perform any and all forms of treatment, medication, and therapy that may be necessary. I understand that the use of local anesthetics agents embodies certain risk and consent to their use as deemed appropriate by Maria C. Hoekstra, DDS, PC. To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect or incomplete information can be dangerous to my/the patient's health. It is my responsibility to inform the dental office of any change in medical health or status.

FOR ADULT
NAME OF PATIENT: _____

SIGNATURE OF PATIENT: _____ DATE: _____

FOR MINOR
NAME OF GUARDIAN: _____

SIGNATURE OF RESPONSIBLE PARTY: _____ DATE: _____

HANDLE ME WITH CARE

PLEASE CHECK THE BOX NEXT TO THE STATEMENT(S) THAT CONCERNS YOU OR DESCRIBES YOUR SITUATION BEST

[ ] I gag easily.
[ ] I feel out of control when lying down in a dental chair.
[ ] I have not been to the dentist in a long time and I feel uncomfortable or nervous.
[ ] Pain relief is a top priority for me.
[ ] I do not like shots / I have a bad reaction to shots.
[ ] Please tell me what I need to know about my mouth so that I can make an informed decision.
[ ] My teeth are very sensitive.
[ ] I do not like my smile.
[ ] Food gets stuck in between my teeth.
[ ] I would like my teeth to be whiter.
[ ] My gums bleed when I brush my teeth or when I'm flossing.
[ ] I do not like the sound of picking and scraping on my teeth.
[ ] I hate the noise of the drill.
[ ] I want to know all costs up front.
[ ] I have difficulties listening and remembering what I hear while sitting in the dental chair.
[ ] I have health problems and questions that we need to discuss.
[ ] I also want you to know: _____

_____

Notice of Privacy Practices & HIPAA Consent

Patient Privacy is important to our practice. We are required by law to maintain privacy of Protected Health Information (PHI) and to provide individuals with notice of our legal duties and privacy practices with respect to PHI.

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you (the patient). The Notice contains a Patient Rights section describing your rights under the law (this may be requested at the front desk). You have the right to review our full Notice before signing Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict protected health information about you that is used or disclosed for treatment, payment or healthcare operations.

By signing this form, you consent to our use and disclosure of protected health information about your treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- ✓ Protected health information may be disclosed or used for treatment, payment or health care operations.
- ✓ The Practice may send patient information relating to my treatment, health, or payment by email or other electronic means, without encryption. The Practice will not email such sensitive personal information such as Social Security number, credit card number, or positive HIV status, unless the patient insists.
- ✓ The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- ✓ The Practice reserves the right to change the Notice of Privacy Policy.
- ✓ The patient has the right to restrict the use of their information.
- ✓ The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- ✓ The Practice may condition treatment upon execution of this Consent. No insurance can be billed on the patient's behalf without this signed HIPAA consent form; therefore payment in full is required at the time services are rendered.

Information Sharing: Please list any individuals we can share your personal information with, other than healthcare providers.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

_____ _____

Signature *Date*

_____

Relationship to Patient (if other than patient)

Financial Consent & Office Guidelines

Maria C. Hoekstra, DDS, PC is committed to providing all patients with exceptional service and quality care. Please review our financial consent and office guidelines.

FINANCIAL OBLIGATION & PAYMENT GUIDELINES

I understand that any responsibility for payment of services provided in this office for myself and my dependent(s) is mine, due and payable at the time services are rendered. If applicable, I understand that I am responsible for any portion of fees for services rendered not covered by my dental insurance. I acknowledge that I am responsible for all fees necessary to collect my account. I understand that it is my responsibility to know my insurance plan/policy coverage. I understand that if a pre-treatment estimate has been sent to my insurance company that this is not a guarantee of payment.

All balances must be paid in full within 90 days.

PAYMENT OPTIONS

Maria C. Hoekstra, DDS, PC accepts cash, checks and all major credit cards as forms of payment.

We extend a 6% courtesy to our patients who pay in-full, on the day of service, with cash or check.

Payment plan options are available, subject to credit approval, through Care Credit. Care Credit offers deferred interest plans along with extended payment plans. Log on to www.carecredit.com or call (800) 365-8295 for more information. Our business team would be happy to assist you with the application process, if you so desire.

If you have any questions, please do not hesitate to ask. We have a team of dedicated business professionals who are welcome to assist you with any financial concerns. Thank you for your cooperation and understanding as we institute these guidelines to help us better serve the needs of all patients.

CANCELLATION GUIDELINE

We respect the importance of your time and work hard to schedule appointments that accommodate the scheduling needs of all of our patients. Out of respect for our other patients, we ask that you notify us at least 24 hours prior to your appointment if you are unable to keep your reserved time. Failure to notify us outside of 24 hours may result in a $40 fee.

I have read and understand the above guidelines.

Signature of Patient or Guardian	Date