

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 _____

DENTAL INSURANCE INFORMATION [] 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 recently had inner ear surgery? *If yes, when:* _____

[] Yes [] No Have you recently had eye surgery? *If yes, when:* _____

[] Yes [] No Have you recently had Emphysema? *If yes, how long:* _____

[] 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 Fluoride in your water at home?

[] 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 have prolonged bleeding or take an anticoagulant (blood thinner)?

[] Yes [] No Do you use/consume tobacco products, controlled substances or marijuana?

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: _____

Please list any medications you are currently taking

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

- | | | |
|--------------------------|--------------------------|--------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Attack / Failure |
| <input type="checkbox"/> | <input type="checkbox"/> | Artificial Heart Valve |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Murmur |
| <input type="checkbox"/> | <input type="checkbox"/> | Mitral Valve Prolapse |
| <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic Fever |
| <input type="checkbox"/> | <input type="checkbox"/> | Scarlet Fever |
| <input type="checkbox"/> | <input type="checkbox"/> | A-Fib / Irregular Heartbeat |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Pacemaker |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Stents |
| <input type="checkbox"/> | <input type="checkbox"/> | Congenital Heart Disorder |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Trouble / Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Angina / Chest Pains |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood Disease / Transfusion |
| <input type="checkbox"/> | <input type="checkbox"/> | Anemia |
| <hr/> | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy / Seizures |
| <input type="checkbox"/> | <input type="checkbox"/> | Fainting Spells / Dizziness |
| <input type="checkbox"/> | <input type="checkbox"/> | High / Low Blood Pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | Pre-Diabetes / High Blood Sugar |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> | Hypoglycemia |
| <input type="checkbox"/> | <input type="checkbox"/> | Excessive Thirst |
| <hr/> | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Stomach / Intestinal Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Acid Reflux / Heartburn |
| <input type="checkbox"/> | <input type="checkbox"/> | Ulcers |
| <input type="checkbox"/> | <input type="checkbox"/> | Liver Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | High Cholesterol |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis A, B, or C |
| <hr/> | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Sinus Trouble |
| <input type="checkbox"/> | <input type="checkbox"/> | Thyroid Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis / Gout |
| <input type="checkbox"/> | <input type="checkbox"/> | Osteoporosis |
| <input type="checkbox"/> | <input type="checkbox"/> | Artificial Joint |
| <input type="checkbox"/> | <input type="checkbox"/> | Autoimmune Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Excessive Dry Mouth |
| <input type="checkbox"/> | <input type="checkbox"/> | Lung Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent Cough |
| <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis |
| <hr/> | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent Headaches |
| <input type="checkbox"/> | <input type="checkbox"/> | Head / Neck Injury |
| <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma / Eye Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke |
| <input type="checkbox"/> | <input type="checkbox"/> | Herpes / Cold Sores / Fever Blisters |
| <input type="checkbox"/> | <input type="checkbox"/> | Sexually Transmitted Disease (STD) |
| <input type="checkbox"/> | <input type="checkbox"/> | AIDS / HIV Positive |

- | | | |
|--------------------------|--------------------------|-----------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Alzheimer's Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Anxiety |
| <input type="checkbox"/> | <input type="checkbox"/> | Eating Disorder |
| <input type="checkbox"/> | <input type="checkbox"/> | Psychiatric Care |
| <input type="checkbox"/> | <input type="checkbox"/> | Depression |
| <input type="checkbox"/> | <input type="checkbox"/> | Alcoholism / Drug Addiction |
-

- | | | |
|--------------------------|--------------------------|---------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Excessive Snoring |
| <input type="checkbox"/> | <input type="checkbox"/> | Sleep Apnea / CPAP |
| <input type="checkbox"/> | <input type="checkbox"/> | Recent Weight Loss |
| <input type="checkbox"/> | <input type="checkbox"/> | Anaphylaxis (allergic reaction) |
-

- | | | |
|--------------------------|--------------------------|-----------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Orthodontic Treatment |
|--------------------------|--------------------------|-----------------------|

If so, when? _____

- | | | |
|--------------------------|--------------------------|--------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Pain in Jaw Joints / TMJ |
| <input type="checkbox"/> | <input type="checkbox"/> | Popping or Cracking of the Jaw |
| <input type="checkbox"/> | <input type="checkbox"/> | Clenching or Grinding of Teeth |
| <input type="checkbox"/> | <input type="checkbox"/> | Occlusal Guard / Bite Splint |

If you said yes to any of the following, please give details:

Artificial Heart Valve:

Heart Attack / Failure:

Heart Murmur:

Mitral Valve Prolapse:

Rheumatic Fever:

Artificial Joint:

Hepatitis A, B or C:

Have you ever had any serious illness not listed?

Y N If yes, please describe:

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.

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