

Health History

Name _____ Date _____

What is the reason for your visit today? _____

Are you satisfied with your teeth's appearance? No Yes

Are you interested in Professional Whitening of your teeth? No Yes

Are you interested in straightening of your teeth? No Yes

Are you interested in bad breath management techniques? No Yes

Date of: Last Dental Visit _____ Last Dental Cleaning _____ Last Full Mouth X-Rays _____

What was done at your last dental visit _____

How often do you have dental examinations _____ Previous Dentist's Name _____

Telephone _____ Address _____

How often do you brush your teeth _____ Do you use electric toothbrush No Yes

How often do you floss? _____ What other dental aids do you use (toothpick, etc.) _____

Do you have any dental problems now? No Yes

If yes, please describe _____

Do you feel nervous about having dental treatment? No Yes

If yes, what is your biggest concern? _____

Have you ever had an upsetting dental experience No Yes

If yes, please describe _____

Is there anything else about having dental treatment that you would like us to know? _____

What are your hobbies or special interests (sports etc.) _____

Are any of your teeth sensitive to:			Have you ever had		
• Hot or cold?	No	Yes	• Orthodontic treatment?	No	Yes
• Sweets?	No	Yes	• Oral Surgery?	No	Yes
• Biting or chewing?	No	Yes	• Periodontal (gum) treatment	No	Yes
• Have you noticed any mouth odors or bad tastes	No	Yes	• A bite plate or mouth guard	No	Yes
• Do you frequently get cold sores, blisters or any other oral lesions?	No	Yes	• A serious injury to the mouth or head?	No	Yes
• Do your gums bleed or hurt?	No	Yes	Have you experienced:		
• Have your parents experienced gum disease or tooth loss?	No	Yes	• Headaches, neckaches or shoulder aches	No	Yes
• Have you noticed any loose teeth or change in your bite	No	Yes	• Sore muscles (neck, shoulders, side of face)	No	Yes

• Does food tend to become caught in between your teeth	No	Yes	• Pain (side of face, joint, ear?)	No	Yes
Do you			• Clicking or popping of the jaw	No	Yes
• Clench or grind teeth while awake or asleep	No	Yes	• Difficulty in chewing on either side of the mouth?	No	Yes
• Bite your lips or cheeks regularly	No	Yes	• Difficulty in opening or closing the mouth?	No	Yes
• Mouth breathe while awake or asleep?	No	Yes	• Have tired jaws especially in the morning?	No	Yes

Date of last health care exam: _____ What was this exam for? _____

Have you been hospitalized in the last 5 years? No Yes

If yes, reason: _____

Are you currently receiving care?.....No Yes ► If yes, nature of care: _____

Please list all the names and phone numbers of the physicians who are currently providing you care:

1. _____
2. _____
3. _____

For the following questions circle yes or no. Your answers are for our records only and will be confidential. Please note that during your initial visit you will be asked some questions about your response. Our team may ask additional questions concerning your health.

Heart (Surgery, Disease, Attack)	No	Yes	Heart Murmur	No	Yes
Latex Sensitivity	No	Yes	Anemia	No	Yes
Diabetes	No	Yes	Previous Biopsies	No	Yes
Epilepsy	No	Yes	Slow-Healing Mouth Sores	No	Yes
Hepatitis, Any Form (specify)	No	Yes	Other Infections	No	Yes
Rheumatic Fever	No	Yes	Recurrent Illnesses	No	Yes
Asthma	No	Yes	Psychosis	No	Yes
HIV Positive or AIDS Related Complex	No	Yes	Liver Disease (including Jaundice)	No	Yes
Mitral valve prolapse	No	Yes	Unintentional Weight Loss/Gain	No	Yes
Abnormal Heart Condition	No	Yes	Glaucoma	No	Yes
Kidney Disease	No	Yes	Abnormal Bleeding from a cut	No	Yes
Joint Replacement	No	Yes	Sore/Enlarged Lymph Nodes	No	Yes
Venereal Disease	No	Yes	Emphysema or other Respiratory Illnesses	No	Yes

Women: • Are you pregnant? _____ • If no, are you planning a pregnancy in the near future? No Yes

Are you a nursing mother?..... No Yes • Are you taking birth control pills? No Yes

Are you required to Pre-Medicate before dental treatment? No Yes

Abnormal Blood Pressure? (Please circle)..... No Yes ▶ If yes, what is it usually: S /D.....

Are you allergic or have you had a reaction to:

a. Local anesthetics No Yes

b. Penicillin or other antibiotics No Yes

c. Aspirin No Yes

d. Codeine, valium or other sedatives..... No Yes

e. Other _____

Do you smoke / chew tobacco? ,..... No Yes ▶ If so, how much do you smoke per day? _____

Please list any medications you are currently taking:

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

Are you taking Tagamet (Cimetidine)? No Yes ▶ If yes, how often? _____

Do you take Antacids? No Yes ▶ If yes, how often? _____

Are you taking any herbal supplements?..... No Yes ▶ If yes, which ones? _____

Diet: Restricted Diet _____ How many meals a day _____ Food Allergies _____

Sugar in your diet: None Slight Moderate High

Do you have or have you had any disease, condition or problem not listed? No Yes

If yes, please list _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health and medication.

Patient (Print Name) _____ Patient Signature _____ Date _____

Doctor (Print Name) _____ Doctor Signature _____ Date _____

Payment Policy

We will provide you with a treatment plan estimating your cost and any insurance benefits for dental care that you may need. Our practice requests payment at the conclusion of each visit. For patients with insurance, the *estimated* co-payment is requested at this time. As a courtesy, we will be pleased to submit insurance claims on our patient's behalf. Please note that any remaining balance, after insurance payment or denial, is the patient's responsibility to pay.

For treatment provided, our practice accepts cash, personal checks, and major credit cards, such as American Express, Visa, MasterCard, and Discover.

If you need to make financial arrangements for your portion, please feel free to do so with our Office Manager, in advance of dental treatment. We will be happy to discuss payment plan options and customize a payment plan for you.

We respect your time and we make a sincere effort to see all our patients on time. We ask that you respect our time and call us 48 business hours in advance, if you must cancel or reschedule your appointment. We waive the fee the first time you cancel without 48 hours notice, as we know emergencies do arise. **We charge a broken appointment fee of \$95.00** the second time your appointment is cancelled with less than 48 hours notice. The third time this occurs, we regret to charge you **\$125.00 for broken appointment**. Please understand any changes in our schedule affects patients waiting to complete their dental care.

I have read and understand the practice's payment policy. Accounts not paid in a timely manner are subject to a late fee. I understand that if the terms of any payment agreement are broken, the account will immediately be turned over to a third party or collection agency.

Signature of patient and/or guarantor

Date

Consent for Internet Communications *(optional - you May Refuse to Sign This Acknowledgement)*

I grant my permission to Nick Levi, DDS to upload and store confidential patient information — including account information, appointment information and clinical information — to the secured web site for Nick Levi, DDS I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand Nick Levi, DDS and myself are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that Nick Levi, DDS is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand Nick Levi, DDS is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the Nick Levi, DDS web site with my ID and password. I also agree to immediately notify Nick Levi, DDS of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns. I also understand State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand Nick Levi, DDS will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my patient information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that Nick Levi, DDS has the right to monitor, retrieve, store, upload and use my patient information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand Nick Levi, DDS will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand Nick Levi, DDS CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

I have read the information above regarding the secured uploading of patient information to the web site for Nick Levi, DDS and grant Nick Levi, DDS permission to securely upload my patient information to the web site.

Date: _____ e-mail _____ Relationship to Patient: _____

Signature of patient and/or guardian

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****you May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

{Please Print Name}

{Signature}

{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

ACKNOWLEDGEMENT OF RECEIPT OF THE DENTAL MATERIALS FACT SHEET

I, _____ have received a copy of the Dental Materials Fact Sheet as required by law.

{Please Print Name}

{Signature}

{Date}

PATIENT REGISTRATION

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

DATE				1
LAST NAME		FIRST	M.I.	
PREFERS TO BE CALLED BY				
ADDRESS				
CITY		STATE	ZIP	
HOME PHONE NO.			FAX	
CELL			EMAIL	
BIRTHDATE	AGE	MALE	FEMALE	
MARRIED	SINGLE	DIVORCED	WIDOWED	
SOCIAL SECURITY NO.				
DATE				
LAST NAME		FIRST	M.I.	
ADDRESS				
CITY		STATE	ZIP	
HOME PHONE NO.				
BIRTHDATE	AGE	MALE	FEMALE	
SCHOOL			GRADE	
SOCIAL SECURITY NO.				

IF YOUR CHILD'S LAST NAME AND/OR ADDRESS ARE NOT THE SAME AS YOURS, FILL IN THE TOP BOX ALSO

DENTAL INSURANCE		2
PRIMARY CARRIER		
INSURANCE COMPANY		
GROUP NO.		
EMPLOYER NAME		
INSURED'S NAME		
DATE OF BIRTH	RELATIONSHIP TO PATIENT	
INSURED'S I.D. NO.		
INSURED'S SOCIAL SECURITY NO.		
SECONDARY CARRIER		
INSURANCE COMPANY		
GROUP NO.		
EMPLOYER NAME		
INSURED'S NAME		
DATE OF BIRTH	RELATIONSHIP TO PATIENT	
INSURED'S I.D. NO.		
INSURED'S SOCIAL SECURITY NO.		

IF THIS APPOINTMENT IS FOR YOU START HERE

IF THIS APPOINTMENT IS FOR YOUR CHILD START HERE

ACCOUNT INFORMATION		4
PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT		
NAME		
RELATIONSHIP TO PATIENT	SOCIAL SECURITY NO.	
ADDRESS		
CITY	STATE	ZIP
PHONE NO.		
YOU		
NAME		
OCCUPATION		
EMPLOYER'S NAME		
ADDRESS	CITY	
PHONE NO.	FAX NO.	
YOUR SPOUSE		
NAME		
OCCUPATION		
EMPLOYER'S NAME		
ADDRESS	CITY	
PHONE NO.	FAX NO.	

GETTING TO KNOW YOU		3
IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE?		
NAME:	RELATIONSHIP:	
YOU WERE REFERRED TO US BY		
YOUR FORMER ADDRESS		
CITY	STATE	ZIP
PERSON TO CONTACT FOR EMERGENCY		
PHONE NUMBER		
ADDRESS		
CITY	STATE	ZIP
CLOSEST RELATIVE NOT LIVING WITH YOU		
PHONE NUMBER		
ADDRESS		
CITY	STATE	ZIP