



# DENTAL HEALTH ASSOCIATES

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Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you receive. Thank you for answering the following questions.

- Are you under a physician's care now? ( ) Yes ( ) No If yes, explain: \_\_\_\_\_
Have you ever been hospitalized or had a major operation?( ) Yes ( ) No If yes, explain: \_\_\_\_\_
Have you ever had a serious head or neck injury?( ) Yes ( ) No If yes, explain: \_\_\_\_\_
Are you taking any medications, pill, or drugs?( ) Yes ( ) No If yes, explain: \_\_\_\_\_
Do you take, or have you taken, Phen-Fen or Redux?( ) Yes ( ) No \_\_\_\_\_
Are you on a special diet?( ) Yes ( ) No \_\_\_\_\_
Do you use tobacco?( ) Yes ( ) No \_\_\_\_\_
Do you use controlled substances?( ) Yes ( ) No \_\_\_\_\_

WOMEN: are you
( ) Pregnant/trying to get pregnant? ( ) Nursing?
( ) Taking oral contraceptives?

Are you allergic to any of the following?
( ) Aspirin ( ) Penicillin ( ) Codeine ( ) Acrylic ( ) Metal ( ) Latex ( ) Local Anesthetics
( ) Other If yes, please explain: \_\_\_\_\_

- Do you have, or have you had, any of the following?
( ) AIDS/HIV Positive ( ) Chest Pains ( ) Frequent Headaches ( ) Irregular Heartbeat ( ) Scarlet Fever
( ) Alzheimer's Disease ( ) Cold Sores/Fever blisters ( ) Genital Herpes ( ) Kidney Problems ( ) Shingles
( ) Anaphylaxis ( ) Congenital Heart Disorder ( ) Glaucoma ( ) Leukemia ( ) Sickle Cell Disease
( ) Anemia ( ) Convulsions ( ) Hay Fever ( ) Liver Disease ( ) Sinus Trouble
( ) Angina ( ) Cortisone Medicine ( ) Heart Attack/Failure ( ) Low Blood Pressure ( ) Spina Bifida
( ) Arthritis/Gout ( ) Diabetes ( ) Heart Murmur ( ) Lung Disease ( ) Stomach/Intestine Disease
( ) Artificial Heart Valve ( ) Drug Addiction ( ) Heart Pace Maker ( ) Mitral Valve Prolapse ( ) Stroke
( ) Artificial Joint ( ) Easily Winded ( ) Heart Trouble/Disease ( ) Pain in Jaw Joints ( ) Swelling of Limbs
( ) Asthma ( ) Emphysema ( ) Hemophilia ( ) Parathyroid Disease ( ) Thyroid Disease
( ) Blood Disease ( ) Epillepsy ( ) Hepatitis A ( ) Psychiatric Care ( ) Tonsillitis
( ) Blood Transfusion ( ) Excessive Bleeding ( ) Hepatitis B or C ( ) Radiation Treatments ( ) Tuberculosis
( ) Breathing Problems ( ) Excessive Thirst ( ) Herpes ( ) Recent Weight Loss ( ) Tumors or Growths
( ) Bruise Easily ( ) Fainting Spells/Dizziness ( ) High Blood Pressure ( ) Renal Dialysis ( ) Ulcers
( ) Cancer ( ) Frequent Cough ( ) Hives or Rash ( ) Rheumatic Fever ( ) Venereal Disease
( ) Chemotherapy ( ) Frequent Diarrhea ( ) Hypoglycemia ( ) Rheumatism ( ) Yellow Jaundice

Have you ever had any serious illness not listed above? ( ) YES ( ) NO If yes, please explain: \_\_\_\_\_

Comments: \_\_\_\_\_

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN \_\_\_\_\_ DATE \_\_\_\_\_

**ASSIGNMENT AND RELEASE**

I hereby authorize payment directly to Dr. Calvano/ La Grua for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges and services rendered to me or my dependants, whether or not paid by insurance. I authorize the above doctor(s) and /or any provider or supplier of services in this office to release any of my medical or financial information required to secure payment of benefits and to carry out any necessary treatment, payment activities, and healthcare operations. I authorize the use of this signature (at the end of this form) on all insurance submissions.

**FINANCIAL POLICY**

Payment of fees and co-payments/deductibles are expected at the time of service. In the event that my account must be turned over for outside collection, I agree to pay all costs related to collection, to include any court costs and attorney fees that may accrue, and an office collection fee of \$ 35.00. I understand that any account information necessary for collection will be released to a collection company that may affect my credit report. I also understand that there is a 1.5 % finance charge for any/all balances that I am billed for and a \$35.00 returned check fee for any check returned for insufficient funds.

**OFFICE POLICY**

Appointments: a minimum charge may be made for missed or cancelled appointments without prior notification of 24 hours. I understand that failure to give a 24 hour notice that I cannot keep a reserved appointment will result in a missed appointment fee of \$ 50.00 and, should this happen three times, will result in dismissal from the practice. Our office reserves the right to refuse appointments for late cancellations as well as failure to attend. PLEASE REMEMBER THAT ONCE AN APPOINTMENT IS MADE, THIS TIME IS RESERVED ESPECIALLY FOR YOU

**CONSENT FOR USE/DISCLOSURE OF HEALTH INFORMATION**

By signing this form you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and health care operations. Your signature also indicates that you have had full opportunity to read and consider our Notice of Privacy Practices, and that you understand that you have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the contact person listed on that notice. Please understand that revocation of this consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you and or to continue treating you if you revoke this Consent

I, THE UNDERSIGNED, UNDERSTAND AND AGREE TO THE POLICIES STATED ABOVE. I CERTIFY THAT THE INFORMATION ON THIS FORM IS ACCURATE, TO THE BEST OF MY KNOWLEDGE.

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Date

Signature (Guardian if under 18 years of age)