

Health History Form



American Dental Association
www.ada.org

E-mail: _____

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:			Home Phone: <i>Include area code</i>		Business/Cell Phone: <i>Include area code</i>	
Last	First	Middle	()	()		
Address:			City:	State:	Zip:	
<i>Mailing address</i>						
Occupation:			Height:	Weight:	Date of birth:	Sex: M F
SS# or Patient ID:	Emergency Contact:		Relationship:	Home Phone:	Cell Phone:	
				()	()	
<i>include area codes</i>						
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: <i>(Check DK if you Don't Know the answer to the question)</i>						
Active Tuberculosis.....						Yes No DK
Persistent cough greater than a 3 week duration.....						<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Cough that produces blood.....						<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Been exposed to anyone with tuberculosis.....						<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
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		Yes	No	DK
Do your gums bleed when you brush or floss?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have earaches or neck pains?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive to cold, hot, sweets or pressure?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any clicking, popping or discomfort in the jaw?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does food or floss catch between your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you brux or grind your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your mouth dry?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have sores or ulcers in your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any periodontal (gum) treatments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you wear dentures or partials?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had orthodontic (braces) treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you participate in active recreational activities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any problems associated with previous dental treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had a serious injury to your head or mouth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your home water supply fluoridated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Date of your last dental exam:			
Do you drink bottled or filtered water?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	What was done at that time?			
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY				Date of last dental x-rays:			
Are you currently experiencing dental pain or discomfort?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
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		Yes	No	DK
Are you now under the care of a physician?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you had a serious illness, operation or been hospitalized in the past 5 years?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physician Name:				Phone: <i>Include area code</i>			
				()			
Address/City/State/Zip:				If yes, what was the illness or problem?			
Are you in good health?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you taking or have you recently taken any prescription or over the counter medicine(s)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has there been any change in your general health within the past year?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements:			
If yes, what condition is being treated?				_____			

Date of last physical exam:				_____			

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

<p>(Check DK if you Don't Know the answer to the question)</p> <p>Do you wear contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Date: _____ If yes, have you had any complications? _____</p> <p>Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Date Treatment began: _____</p>	<p>Do you use controlled substances (drugs)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Do you use tobacco (smoking, snuff, chew, bidis)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK If so, how interested are you in stopping? (Circle one) VERY / SOMEWHAT / NOT INTERESTED</p> <p>Do you drink alcoholic beverages? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK If yes, how much alcohol did you drink in the last 24 hours? _____ If yes, how much do you typically drink in a week? _____</p>
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<p>Allergies - Are you allergic to or have you had a reaction to: To all yes responses, specify type of reaction. Yes No DK</p> <p>Local anesthetics <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Aspirin <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Penicillin or other antibiotics <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Barbiturates, sedatives, or sleeping pills <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Sulfa drugs <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Codeine or other narcotics <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p>	<p>WOMEN ONLY Are you:</p> <p>Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Number of weeks: _____</p> <p>Taking birth control pills or hormonal replacement? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Nursing? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p>
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<p>Allergies - Are you allergic to or have you had a reaction to: To all yes responses, specify type of reaction. Yes No DK</p> <p>Metals <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Latex (rubber) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Iodine <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Hay fever/seasonal <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Animals <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Food <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Other <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p>	<p>Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.</p> <p>Yes No DK</p> <p>Artificial (prosthetic) heart valve <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Previous infective endocarditis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Damaged valves in transplanted heart <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Congenital heart disease (CHD)</p> <p>Unrepaired, cyanotic CHD <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Repaired (completely) in last 6 months <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Repaired CHD with residual defects <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p>
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<p><i>Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.</i></p> <p>Yes No DK</p> <p>Cardiovascular disease <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Angina <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Arteriosclerosis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Congestive heart failure <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Damaged heart valves <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Heart attack <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Heart murmur <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Low blood pressure <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>High blood pressure <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Other congenital heart defects <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p>	<p>Yes No DK</p> <p>Mitral valve prolapse <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Rheumatic fever <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Rheumatic heart disease <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Abnormal bleeding <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Blood transfusion <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK If yes, date: _____</p> <p>Hemophilia <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>AIDS or HIV infection <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p>	<p>Yes No DK</p> <p>Autoimmune disease <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Rheumatoid arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Systemic lupus erythematosus <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Bronchitis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Sinus trouble <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Cancer/Chemotherapy/ Radiation Treatment <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Chest pain upon exertion <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Chronic pain <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Diabetes Type I or II <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Eating disorder <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Malnutrition <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Gastrointestinal disease <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>G.E. Reflux/persistent heartburn <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Thyroid problems <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p>
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Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? Yes No DK

Name of physician or dentist making recommendation: _____ Phone: _____

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

FOR COMPLETION BY DENTIST

Comments: _____

Kenneth C. Nash D.D.S.
1550 Elm Avenue Solvang, CA 93463
(805) 688-5557



INSURANCE INFORMATION

Person responsible for account: Last name: _____ First: _____

Relationship to Patient: _____ Date of Birth: _____ Social Security #: _____

Address (if different from above): _____

City: _____ State: _____ Zip: _____

Insurance Company: _____ Subscriber ID: _____

Group#: _____ Phone: _____

Claims Address: _____

SECONDARY INSURANCE

Insurance Company: _____ Policy Holder: _____

Subscriber ID#: _____ Group #: _____

The responsible party agrees to fill out a new form when any of the above information changes. Wrong information may result in incorrect filing and subsequent charges.

ASSIGNMENT AND RELEASE

I, the undersigned, hereby authorize and direct my insurance carrier to pay directly to Dr. Kenneth C. Nash D.D.S. all insurance benefits, if any, due to me under my insurance plan. I further agree to pay the balance of the charges not paid by my insurance. Any balance that is not paid within 45 days will also be my responsibility. I hereby authorize the release of any information necessary to secure payment of benefits. I also authorize the use of this signature on all insurance submissions. If the patient is a minor, I as a legal guardian give consent for treatment for this, and future services rendered. I have received the Notice of Privacy Practices and I have been provided with an opportunity to review it.

Responsible Person/Patient Signature: _____ Date: _____

Kenneth C. Nash D.D.S.
1550 Elm Avenue Solvang, CA 93463
(805) 688-5557



Privacy Policy

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I authorize the release of any information concerning my (or my child's) health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I authorize the release of any information concerning my (or my child's) health care, advice and treatment to another dentist.

I understand that I may withdraw or revoke my authorization at any time. I may revoke this authorization by notifying this practice in writing.

I understand that by signing this Consent form, I am giving my consent to disclose and discuss my protected health information to carry out treatment, payment activities and health care operations.

The undersigned hereby authorizes Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I have read, understand and agree to the above terms and conditions.

Signature of Patient/Legal Guardian

Date

Kenneth C. Nash D.D.S.
1550 Elm Avenue Solvang, CA 93463
(805) 688-5557



Financial Agreement

We are committed to providing you with the highest quality lifetime dental care, so that you may attain optimum oral health. The following is a statement of our Financial Policy, which we require that you read, agree to, and sign prior to any treatment. We are pleased to discuss our professional fees with you at any time. Your clear understanding of the Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy, or your responsibility.

ADULT PATIENTS

Adult patients are responsible for full payment at time of service. _____ (please initial)

MINORS ACCOMPANIED BY AN ADULT

The adult accompanying a minor, his/her parents or guardians, are responsible for full payment at time of service _____ (please initial)

INSURANCE

We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company. Please understand that we will provide an insurance estimate to you however, it is not guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits will determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible. If payment is not received or you claim is denied, you will be responsible for paying the full amount at that time. If you are paid by the insurance company instead of our practice, you then become responsible for the total account balance and payment would be expected immediately. _____ (please initial)

We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. _____ (please initial)

DEDUCTIBLE/CO-PAYMENT

We may ask that you pay the deductible and co-payment, which is the estimated amount, not covered by your insurance company, by cash, check, or credit card or Patient Financing at the time we provide service to you. _____ (please initial)

DELINQUENT PAYMENTS

It is our policy to charge a finance fee of 18% APR for any outstanding patient balances over 90 days. In addition, all payments returned due to non-sufficient funds will be subject to a fee. _____ (please initial)

MISSED APPOINTMENTS

Unless cancelled 24 hours in advance, our policy is to charge a \$50.00 fee for any missed appointments. Please help us service you better by keeping scheduled appointments. _____ (please initial)

REFUND POLICY

You may discontinue treatment and request a refund at any time for any amount that you paid for treatment that you did not receive. Please contact our office if you'd like to request a refund. _____ (please initial)

I _____, confirm that I have read, understand and agree to the above terms and conditions. I hereby authorize payment of insurance benefits directly to the dentist, otherwise payable to me. I understand that my dental care insurance carrier or payer of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payments of service not paid, in whole or on part by my dental care payer.

Signature of Patient/Legal Guardian

Date

Kenneth C. Nash D.D.S.
1550 Elm Avenue Solvang, CA 93463
(805) 688-5557



CONSENT TO RELEASE RECORDS

Dear _____,

(Name of Doctor/Clinic)

I request that you please email all **x-rays** and any **treatment history** you have on file to Dr. Kenneth Nash at Frontdesk@surfdds.com.

Patient Signature (Parent if minor)

Date

Patient Name: _____

Patient DOB: _____