

**MEDICAL HISTORY FORM**

Date: \_\_\_\_\_

Name \_\_\_\_\_  
Last First MI

Home Phone \_\_\_\_\_

Address \_\_\_\_\_

Work Phone \_\_\_\_\_

City/State \_\_\_\_\_ Zip Code \_\_\_\_\_

Cell Phone \_\_\_\_\_

Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Sex M F SSN \_\_\_\_\_

Employer \_\_\_\_\_

Emergency Contact Person \_\_\_\_\_ Phone \_\_\_\_\_

Chief Complaint: \_\_\_\_\_

Referred by: \_\_\_\_\_

Dental Insurance _____	Phone _____
Subscriber Name _____	SSN/ID# _____
Date of Birth _____	Employer _____

**IN THE FOLLOWING QUESTIONS, CHECK "YES" OR "NO", WHICHEVER APPLIES. YOUR ANSWERS ARE FOR OUR RECORDS ONLY AND WILL BE CONSIDERED CONFIDENTIAL INFORMATION.**

1. Has there been any change in your general health within the past year? YES NO
2. Date of last physical examination: \_\_\_\_\_
3. Are you now under the care of a physician? YES NO  
-If yes, for what condition are you being treated? \_\_\_\_\_
4. Name and phone # of your physician \_\_\_\_\_
5. Have you had any serious illness or been hospitalized in the past 5 years? YES NO  
-If yes, what was the nature of the problem \_\_\_\_\_
6. Do you require **antibiotic** pre-medication prior to dental procedures? YES NO
7. Do you have or ever had any of the following conditions?
  - YES NO Heart murmur
  - YES NO Rheumatic Heart Disease
  - YES NO Mitral Valve Prolapse
  - YES NO Cardiovascular disease (heart attack, stroke, bypass)
  - YES NO High or Low blood pressure (**circle one**)
  - YES NO Joint or organ replacement (**circle one**)
  - YES NO Seasonal Allergies
  - YES NO Asthma
  - YES NO Seizures
  - YES NO Persistent diarrhea or recent weight loss

**-OVER-**

- YES NO Diabetes
- YES NO Hepatitis
- YES NO Liver disease
- YES NO Substance abuse
- YES NO Thyroid problems
- YES NO Respiratory problems
- YES NO Arthritis
- YES NO Ulcers
- YES NO Kidney problems
- YES NO Tuberculosis
- YES NO Problems with immune system
- YES NO Persistent swollen glands in neck
- YES NO Cancer
- YES NO Sexually transmitted disease
- YES NO Epilepsy
- YES NO Mental health problems
- YES NO Anemia
- YES NO Abnormal Bleeding

8. Are you allergic to or have you had a reaction to:

- YES NO Local anesthetics
- YES NO Penicillin
- YES NO Sulfa drugs
- YES NO Barbiturates, Sedatives or Sleeping pills
- YES NO Aspirin
- YES NO Iodine
- YES NO Codeine

Other \_\_\_\_\_

- 9. Are you taking any medications including any non-prescription medications? YES NO  
Please list: \_\_\_\_\_
- 10. Have you had any trouble associated with any previous dental treatment? YES NO  
If so, explain: \_\_\_\_\_
- 11. Do you have any disease, condition or problem not list above? YES NO  
If so, explain: \_\_\_\_\_
- 12. Are you wearing contact lenses? YES NO
- 13. Are you wearing removable dental appliances? YES NO
- 14. Do you smoke or have a tobacco habit? YES NO

**Women Only**

- 15. Are you pregnant? YES NO
- 16. Are you nursing? YES NO
- 17. Are you taking birth control pills? YES NO

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his staff, responsible for any error or omissions that I may have made in the completion of this form.

\_\_\_\_\_  
Signature of Patient Date \_\_\_\_\_

## PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree than you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Date: \_\_\_\_\_

**C.R. Anderegg, DDS**  
Periodontics – Implants

*FINANCIAL ARRANGEMENTS*

**DENTAL INSURANCE**

We are happy to file the forms necessary to see that you receive the full benefits of your insurance policy coverage; **however we can make no guarantee of any estimated coverage.** Because the insurance policy is an agreement between you and the insurance company, **we ask that all patients be directly responsible for all charges.** We ask that a co-payment and the deductible be paid at the time of service. We do not file secondary insurance, but we will provide the necessary information for you to collect from your insurance provider. Please know that we will do everything possible to see that you receive the full benefits of your policy.

**METHODS OF PAYMENT**

1. Cash, Check or Credit Card (MasterCard or Visa)
2. Dental Insurance
3. Payment Plan (3rd party financing)- For patients who desire a monthly payment plan we have arrangements with a finance company (Care Credit). There are no application fees, no down payment is necessary and the loan can be interest-free. Applications are available from our front desk staff and approval is provided quickly.

**RELATED INFORMATION**

I understand that I am responsible for all charges incurred. I agree to pay finance charges on any balance that is over 90 days at 12% annually. I understand that any returned check will accrue a \$20.00 service charge. I agree to pay any collection fees or attorney expenses should it be necessary to refer this account to a collection agency and I understand that any unpaid accounts will be reported to credit bureaus.

\_\_\_\_\_

Patient or responsible party

\_\_\_\_\_

Date