Health Information and History

Today's Date: _____

Patient's Name: _____ **Date of Birth**: _____

If you are completing this form for another person:
Your name: _____ Phone: _____ Relationship: _____

Emergency Contact: (If not listed above)
Name: _____ Phone: _____ Relationship: _____

Primary Physician: _____ Phone: _____ City & State: _____
Date of last physical examination: _____ Date of last blood test/work up: _____

Are you under the care of a Physician/Specialist ?
Name: _____ Specialty: _____ Phone: _____ City & State: _____
Name: _____ Specialty: _____ Phone: _____ City & State: _____

1. With in the last 3 years, have you been hospitalized or had surgery? □ **Yes** □ **No**
If Yes, please give reasons and dates: _____

2. Have you ever been instructed to take ANY medications or take ANY special precautions before any dental appointments*? □ **Yes** □ **No**
If Yes, please explain: _____

3. Are you taking ANY drugs, medications, or treatments at this time? □ **Yes** □ **No**
(If you brought a complete written list with you, give that to the receptionist instead)
Prescribed: _____
_____
Over-the-counter (OTC) medications (such as Aspirin, Advil, allergy medication, sleeping aids, etc):
_____
Vitamins, natural or herbal preparations and/or dietary supplements:
_____
Are you having or have you ever had radiation or chemotherapy treatments*? □ **Yes** □**No**
If Yes, for how long?_____ Name of facility performing the treatment :_____

4. Are you taking or have you ever taken / been treated with a Bisphosphonate (Fosamax)? □**Yes**□ **No**

5. Are you allergic to or have you ever experienced an unusual reaction to:
___Latex ___Metals or jewelry ___Dental anesthesia (local)
___Fluoride ___Nitrous oxide (laughing gas) ___General anesthesia

6. Are you allergic to or have you ever had any reaction to any of the following drugs?
___Penicillin (or related drugs) ___Tranquilizers (Valium) ___Tetra cycline ___Codeine
___Aspirin / Ibuprofen (Advil, Motrin, Nuprin) ___ Keflex (Cephalexin) ___ Sulfa drugs ___Iodine
___NSAID (Celebrex, Vioxx, Anaprox) ___ Clindamycin (Cleocin) ___Erythromycin

7. Have you had an allergic reaction or unusual response to ANY other medications, drugs, pills, or treatments? □ **Yes** □ **No**
If Yes, please list :_____

Continued on next page… **Reviewed By:** _____

Health Information and History (continued)

Patient's Name: _____

8. Do you have, or have you ever had, any of the following? (Please check Yes or No for each question)

	Yes	No
Congenital heart defects	___	___
Angina or chest pains	___	___
Atherosclerosis	___	___
Congestive heart failure	___	___
Coronary artery disease	___	___
Heart surgery	___	___
If Yes, type & date _____		
Heart attack	___	___
If Yes, date _____		
Rheumatic heart disease / rheumatic fever	___	___
Infective Endocarditis*	___	___
Heart valve(s) damage / Mitral valve prolapse	___	___
Artificial heart valve	___	___
Pacemaker	___	___
Stroke or CVA	___	___
High blood pressure	___	___
Low blood pressure	___	___
Anemia	___	___
Hemophilia or bleeding disorder	___	___
Excessive bleeding from any cut or incident	___	___
Diabetes or blood sugar problems	___	___
Any artificial joint, joint surgery or prosthesis	___	___
If Yes, what join t or area: _____		
When was operation done: _____		
Hepatitis, jaundice, or other liver problems	___	___
Any form of cancer	___	___
An organ transplant	___	___

	Yes	No
Asthma	___	___
Hay fever, skin or allergies	___	___
or allergies in general	___	___
Sinus problems	___	___
Tuberculosis, emphysema or lung disorder	___	___
Skin problems	___	___
A sore or wound that bleeds easily		
or does not heal	___	___
A thyroid problem or disease	___	___
Arthritis	___	___
Glaucoma or any eye diseases	___	___
Epilepsy or other seizure disorder	___	___
Any kidney problems	___	___
Ulcers, acid reflux, or stomach problems	___	___
A compromised immune system	___	___
(Lupus, HIV, AIDS, radiation immune problem, ect.)		
An active sexually transmitted disease (STD)	___	___
Any mental health issues	___	___
Been treated for any psychiatric condition	___	___

Women Only:	**Yes**	**No**
Are you pregnant	___	___
If Yes, what is your due date:_____		
Do you think you might be pregnant	___	___
Are you presently nursing	___	___
Are you using birth control	___	___
Are you taking hormone replacement therapy	___	___

9. Do you have Sleep Apnea or a snoring problem?

If yes please explain: _____

_____

10. Do you have any other conditions, diseases, or medical problems, or is there ANY other information that you would like us to know about, or that we should be made aware of? □ Yes □ No

If Yes, please explain: _____

_____

_____

_____

CONSENT — To the best of my knowledge, all of the preceding information is correct and if there is ever any change in health, or medications, this practice will be informed of the changes without fail. I also consent to allow this practice to contact any healthcare provider(s) and to have the patient's health information released to aid in care and treatment. I also hereby consent to allow diagnosis, proper health care and treatment to be performed by this practice for the above named individual until further notice.

I understand there are no guarantees or warranties in health or dental care.

Signature_____ Date _____

(Parent or guardian, if patient is a minor)

Reviewed By: _____

Aesthetic & Family Dentistry at Richmont Pointe
505 Cornhusker Road, Suite 102
Bellevue, NE 68005 (402)293-1234

Written Financial Policy
Effective July 1, 2009

Thank you for choosing Aesthetic & Family Dentistry. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of our mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment options:

You can choose from: Cash, Check, Visa, MasterCard, Discover and American Express

We offer a 10% courtesy accounting adjustment to patients who do not carry insurance and pay in full for their treatment with cash or check at time of service.

As a service to our patients, we are pleased to offer CareCredit card, North Americas leading patient payment plan. CareCredit lets you begin your dental care treatment immediately-then pay for it over time with low monthly payments that are easy to fit in to your monthly budget.

CareCredit offers a full range of No Interest and Extended Payment Plans ranging from 3 to 60 months without up-front costs, pre-payment penalties or fees.

Aesthetic & Family Dentistry will accept two or three payments for services requiring multiple appointments based on treatment plan. **For larger, more comprehensive treatment plans of $1500 or more, a 10% deposit is required to secure your initial treatment appointment.** This must be received in the office 72 hours prior to your appointment.

We understand that sometimes circumstances arise that prevent us from keeping appointments, if you find it impossible to keep an appointment the following applies:

- We will forgive one missed appointment (up to 60 minutes only) within a 12 month period after which we charge a $50.00 broken appointment fee.
- Missed appointments 60-90 minutes, $100.00
- Missed appointments greater than 90 minutes, $150.00

Aesthetic & Family Dentistry charges $35.00 for returned checks.

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

_____

Patient/Guardian Signature: Date:

_____

Larry A. Cameron D.D.S. Date:

Aesthetic & Family Dentistry
505 Cornhusker Road, Suite 102
Bellevue, NE, 68005
(402)293-1234

NOTICE OF AVAILABILITY OF PRIVACY PRACTICES

You have been notified of the availability of our Privacy Practices Policy which you can request from our office.

Signature_____Date_____

Print Name_____

_____Patient _____Guardian

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement 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)

_____

_____

Entered by
_____Date_____