

PATIENT'S MEDICAL HISTORY

PATIENT'S 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 THAT YOU WILL BE RECEIVING. THANK YOU FOR ANSWERING THE FOLLOWING QUESTIONS.

	YES	NO		YES	NO
1. ARE YOU IN GOOD HEALTH.....	<input type="checkbox"/>	<input type="checkbox"/>	12. HAVE YOU EVER TAKEN FEN-PHEN/REDUX.....	<input type="checkbox"/>	<input type="checkbox"/>
2. HAVE THERE BEEN ANY CHANGES IN YOUR GENERAL HEALTH WITHIN THE PAST YEAR.....	<input type="checkbox"/>	<input type="checkbox"/>	13. HAVE YOU EVER TAKEN FOSAMAX, BONIVA, ACTONEL OR ANY CANCER MEDICATIONS CONTAINING BISPHTHOSPHONATES.....	<input type="checkbox"/>	<input type="checkbox"/>
3. DATE OF YOUR LAST PHYSICAL EXAM: _____			14. HAVE YOU TAKEN VIAGRA, REVATIO, CIALIS OR LEVITRA IN THE LAST 24 HOURS.....	<input type="checkbox"/>	<input type="checkbox"/>
4. PHYSICIAN'S NAME _____ ADDRESS _____ PHONE NO. _____			15. DO YOU USE TOBACCO.....	<input type="checkbox"/>	<input type="checkbox"/>
5. ARE YOU NOW UNDER THE CARE OF A PHYSICIAN.....	<input type="checkbox"/>	<input type="checkbox"/>	16. DO YOU OR HAVE YOU USED CONTROLLED SUBSTANCES.....	<input type="checkbox"/>	<input type="checkbox"/>
6. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS .. PLEASE EXPLAIN. _____	<input type="checkbox"/>	<input type="checkbox"/>	17. ARE YOU WEARING CONTACT LENSES.....	<input type="checkbox"/>	<input type="checkbox"/>
7. ARE YOU TAKING ANY MEDICINE(S) INCLUDING NON-PRESCRIPTION MEDICINE ... IF YES, WHAT MEDICINE(S) ARE YOU TAKING _____	<input type="checkbox"/>	<input type="checkbox"/>	18. DO YOU HAVE A PERSISTENT COUGH OR THROAT CLEARING NOT ASSOCIATED WITH A KNOWN ILLNESS (LASTING MORE THAN 3 WEEKS).....	<input type="checkbox"/>	<input type="checkbox"/>
8. HAVE YOU HAD ANY ABNORMAL BLEEDING ...	<input type="checkbox"/>	<input type="checkbox"/>	19. DO YOU HAVE ANY DISEASE, CONDITION OR PROBLEM NOT LISTED ABOVE THAT YOU THINK I SHOULD KNOW ABOUT.....	<input type="checkbox"/>	<input type="checkbox"/>
9. DO YOU BRUISE EASILY.....	<input type="checkbox"/>	<input type="checkbox"/>	WOMEN ONLY:		
10. HAVE YOU EVER REQUIRED A BLOOD TRANSFUSION	<input type="checkbox"/>	<input type="checkbox"/>	ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT ..	<input type="checkbox"/>	<input type="checkbox"/>
11. HAVE YOU HAD A RECENT WEIGHT LOSS.....	<input type="checkbox"/>	<input type="checkbox"/>	ARE YOU NURSING.....	<input type="checkbox"/>	<input type="checkbox"/>
			ARE YOU TAKING BIRTH CONTROL PILLS.....	<input type="checkbox"/>	<input type="checkbox"/>

	YES	NO		YES	NO
ARE YOU ALLERGIC TO OR HAVE YOU HAD REACTIONS TO:			HIVES OR SKIN RASH.....	<input type="checkbox"/>	<input type="checkbox"/>
LOCAL ANESTHETICS LIKE NOVOCAINE.....	<input type="checkbox"/>	<input type="checkbox"/>	FAINING OR DIZZY SPELLS.....	<input type="checkbox"/>	<input type="checkbox"/>
PENICILLIN OR OTHER ANTIBIOTICS.....	<input type="checkbox"/>	<input type="checkbox"/>	DIABETES.....	<input type="checkbox"/>	<input type="checkbox"/>
SULFA DRUGS.....	<input type="checkbox"/>	<input type="checkbox"/>	AIDS OR HIV INFECTION.....	<input type="checkbox"/>	<input type="checkbox"/>
BARBITURATES, SEDATIVES OR SLEEPING PILLS ...	<input type="checkbox"/>	<input type="checkbox"/>	THYROID PROBLEMS.....	<input type="checkbox"/>	<input type="checkbox"/>
ASPIRIN.....	<input type="checkbox"/>	<input type="checkbox"/>	ALLERGIES.....	<input type="checkbox"/>	<input type="checkbox"/>
IODINE.....	<input type="checkbox"/>	<input type="checkbox"/>	ARTHRITIS OR RHEUMATISM.....	<input type="checkbox"/>	<input type="checkbox"/>
ANY METALS (E.G., NICKEL, MERCURY, ETC.).....	<input type="checkbox"/>	<input type="checkbox"/>	JOINT REPLACEMENT OR IMPLANT.....	<input type="checkbox"/>	<input type="checkbox"/>
LATEX / RUBBER.....	<input type="checkbox"/>	<input type="checkbox"/>	STOMACH ULCER.....	<input type="checkbox"/>	<input type="checkbox"/>
OTHER (PLEASE LIST) _____			KIDNEY TROUBLE.....	<input type="checkbox"/>	<input type="checkbox"/>
DO YOU HAVE OR HAVE YOU EVER HAD THE FOLLOWING:			TUBERCULOSIS.....	<input type="checkbox"/>	<input type="checkbox"/>
RHEUMATIC HEART DISEASE OR RHEUMATIC FEVER	<input type="checkbox"/>	<input type="checkbox"/>	PERSISTENT COUGH.....	<input type="checkbox"/>	<input type="checkbox"/>
SCARLET FEVER.....	<input type="checkbox"/>	<input type="checkbox"/>	COUGH THAT PRODUCES BLOOD.....	<input type="checkbox"/>	<input type="checkbox"/>
HEART DEFECT OR HEART MURMUR.....	<input type="checkbox"/>	<input type="checkbox"/>	CHEMOTHERAPY (CANCER, LEUKEMIA).....	<input type="checkbox"/>	<input type="checkbox"/>
HEART TROUBLE, HEART ATTACK, OR ANGINA	<input type="checkbox"/>	<input type="checkbox"/>	SEXUALLY TRANSMITTED DISEASE.....	<input type="checkbox"/>	<input type="checkbox"/>
CHEST PAIN.....	<input type="checkbox"/>	<input type="checkbox"/>	EPILEPSY OR SEIZURES.....	<input type="checkbox"/>	<input type="checkbox"/>
SHORTNESS OF BREATH.....	<input type="checkbox"/>	<input type="checkbox"/>	ANEMIA.....	<input type="checkbox"/>	<input type="checkbox"/>
PACEMAKER.....	<input type="checkbox"/>	<input type="checkbox"/>	GLAUCOMA.....	<input type="checkbox"/>	<input type="checkbox"/>
HEART SURGERY.....	<input type="checkbox"/>	<input type="checkbox"/>	NERVOUSNESS.....	<input type="checkbox"/>	<input type="checkbox"/>
HIGH/LOW BLOOD PRESSURE.....	<input type="checkbox"/>	<input type="checkbox"/>	TONSILLITIS.....	<input type="checkbox"/>	<input type="checkbox"/>
CONGENITAL HEART PROBLEM.....	<input type="checkbox"/>	<input type="checkbox"/>	TUMORS.....	<input type="checkbox"/>	<input type="checkbox"/>
SWELLING OF FEET, ANKLES, HANDS.....	<input type="checkbox"/>	<input type="checkbox"/>	MENTAL HEALTH CARE.....	<input type="checkbox"/>	<input type="checkbox"/>
HEPATITIS, JAUNDICE OR LIVER DISEASE.....	<input type="checkbox"/>	<input type="checkbox"/>	BACK PROBLEMS.....	<input type="checkbox"/>	<input type="checkbox"/>
STROKE.....	<input type="checkbox"/>	<input type="checkbox"/>	CHEMICAL DEPENDENCY.....	<input type="checkbox"/>	<input type="checkbox"/>
SINUS TROUBLE.....	<input type="checkbox"/>	<input type="checkbox"/>	MITRAL VALVE PROLAPSE.....	<input type="checkbox"/>	<input type="checkbox"/>
LUNG OR BREATHING PROBLEMS.....	<input type="checkbox"/>	<input type="checkbox"/>	CORTISONE TREATMENT.....	<input type="checkbox"/>	<input type="checkbox"/>
ASTHMA OR HAY FEVER.....	<input type="checkbox"/>	<input type="checkbox"/>	COLD SORES/FEVER BLISTERS.....	<input type="checkbox"/>	<input type="checkbox"/>
			HYPOGLYCEMIA.....	<input type="checkbox"/>	<input type="checkbox"/>
			EATING DISORDERS.....	<input type="checkbox"/>	<input type="checkbox"/>

PATIENT'S NUMBER _____

PATIENT'S DENTAL HISTORY

PATIENT'S NAME _____ DATE OF BIRTH _____

REASON FOR THIS VISIT _____

WHEN WAS YOUR LAST DENTAL VISIT _____ WHAT WAS DONE THEN _____

HOW OFTEN DID YOU VISIT THE DENTIST BEFORE THEN _____

PREVIOUS DENTIST (NAME AND LOCATION) _____

HAVE YOU HAD A COMPLETE SERIES OF DENTAL FILMS (X-RAYS) TAKEN WHEN/WHERE _____

HOW OFTEN DO YOU BRUSH YOUR TEETH _____ HOW OFTEN DO YOU FLOSS YOUR TEETH _____

IS YOUR DRINKING WATER FLUORIDATED _____

	YES	NO		YES	NO
DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING	<input type="checkbox"/>	<input type="checkbox"/>	DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY	<input type="checkbox"/>	<input type="checkbox"/>
ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS	<input type="checkbox"/>	<input type="checkbox"/>	HAVE YOU NOTICED ANY LOOSENING OF YOUR TEETH	<input type="checkbox"/>	<input type="checkbox"/>
ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/FOODS	<input type="checkbox"/>	<input type="checkbox"/>	DOES FOOD TEND TO BECOME CAUGHT BETWEEN YOUR TEETH	<input type="checkbox"/>	<input type="checkbox"/>
DO YOU FEEL PAIN TO ANY OF YOUR TEETH	<input type="checkbox"/>	<input type="checkbox"/>	HAVE YOU EVER HAD PERIODONTAL TREATMENT (GUMS)	<input type="checkbox"/>	<input type="checkbox"/>
DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH	<input type="checkbox"/>	<input type="checkbox"/>	EVER WORN A BITE PLATE OR OTHER APPLIANCE.	<input type="checkbox"/>	<input type="checkbox"/>
HAVE YOU HAD ANY HEAD, NECK OR JAW INJURIES	<input type="checkbox"/>	<input type="checkbox"/>	HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS IN THE PAST	<input type="checkbox"/>	<input type="checkbox"/>
HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING PROBLEMS IN YOUR JAW?			HAVE YOU EVER HAD ANY PROLONGED BLEEDING FOLLOWING EXTRACTIONS	<input type="checkbox"/>	<input type="checkbox"/>
CLICKING	<input type="checkbox"/>	<input type="checkbox"/>	DO YOU WEAR DENTURES OR PARTIALS	<input type="checkbox"/>	<input type="checkbox"/>
PAIN (JOINT, EAR, SIDE OF FACE)	<input type="checkbox"/>	<input type="checkbox"/>	IF YES, DATE OF PLACEMENT _____		
DIFFICULTY IN OPENING OR CLOSING	<input type="checkbox"/>	<input type="checkbox"/>	HAVE YOU EVER RECEIVED ORAL HYGIENE INSTRUCTIONS REGARDING THE CARE OF YOUR TEETH AND GUMS	<input type="checkbox"/>	<input type="checkbox"/>
DIFFICULTY IN CHEWING	<input type="checkbox"/>	<input type="checkbox"/>			
DO YOU HAVE FREQUENT HEADACHES	<input type="checkbox"/>	<input type="checkbox"/>			
DO YOU CLENCH OR GRIND YOUR TEETH	<input type="checkbox"/>	<input type="checkbox"/>			

IF YOU COULD CHANGE ANYTHING ABOUT YOUR SMILE, WHAT WOULD YOU CHANGE? _____

AUTHORIZATION AND RELEASE

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION TO THE BEST OF MY KNOWLEDGE. THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. 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 PAYORS 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.

X _____ DATE _____
SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR

DOCTOR'S COMMENTS _____

_____ SIGNATURE _____ DATE _____



Billings Dental Care Patient Financial Policy

Welcome to Billings Dental Care. We want to make sure your visits productive and enjoyable. We are happy to answer any and all questions regarding insurance plans and payment policies.

Billings Dental Care is a fee for service office that participates with many dental insurance plans.

Dental Insurance Policies

Many of our patients have dental insurance. While your dental insurance policy is an agreement between you and your insurance company, we will be happy to assist you in preparing and sending in necessary forms. Please remember that no insurance company attempts to cover all dental costs. Payment to our office remains your responsibility, regardless of how much your insurance does or does not pay. For extensive treatments, most insurance companies require pretreatment estimates. We will be happy to supply any information your dental insurance carrier needs and help you receive the maximum benefits.

Insurance claims for your carriers are filled as a courtesy at no charge to you.

- To assist you with your payment, our office accepts Visa and Master card, Discover and American Express
- Personal checks are accepted.
- We accept Care Credit.
- Financing options are available through Billings Dental Care.

If you are a member of a dental insurance plan, it is your responsibility to:

- Provide us with information relative to your claim, including INSURANCE CARD, employer, birth date, address, and social security number.
- Pay your deductible or co-payment at time of service.
- Pay for services not covered by our insurance carrier.
- We will only pursue insurance payments for TWO MONTHS. After that, if your insurance hasn't paid, the patient must pay the entire bill. We will continue to assist you in receiving reimbursement from the insurance company.

When your bill is unpaid a collection agency may be chosen to manage delinquent accounts. If your account is placed with a collection agency you will be responsible for all costs of collection. A 7.5% rate will be applied to all delinquent accounts monthly.

Cancellation Policy

*****We require a 24 hour cancellation notice for a scheduled appointment. A \$50 charge will be applied to all appointments cancelled without 24 hour notice and missed appointments.**

I have read and fully understand my financial responsibility under this policy.

Patient/Guardian Signature

Date

Patient Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment, including direct and indirect treatment by other healthcare providers involved in treatment.
- Obtaining payment for third party payers (insurance company)
- The day to day healthcare operations of the practice.

I have also been informed of and given the rights to review a d secure a copy of Notice of Privacy Practices, which contains a complex description of the uses and disclosures of my protected health information, and my rights under HIPPA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of notice.

I understand I have the right to request restrictions on how to protect health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to the requested restrictions. However if you do not agree you are bound to comply with this restriction.

I understand that I may revoke this consent in writing at any time. However any use or disclosure that occurred prior to the date I revoked this consent is not affected.

Date: __/__/____

Print Patient Name: _____

Sign: _____

Relationship to Patient: _____

Patient Name: _____

Pharmacy Information

Electronic prescribing is required for all New York State prescriptions. In order to expedite the prescription process at the end of your visit today, we request that you fill out the following:

Pharmacy Name, Location & Zip Code:

Pharmacy Telephone Number:
