Health History Form

ADA American Dental Association®
America's leading advocate for oral health

Email: 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: *Last First Middle*
Home Phone: *Include area code* ( )
Business/Cell Phone: *Include area code* ( )

Address: *Mailing address*
City: State: Zip:

Occupation:
Height: Weight: Date of Birth: Sex: M F

SS# or Patient ID: Emergency Contact:
Relationship: Home Phone: *Include area code* ( ) Cell Phone: *Include area code* ( )

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: *(Check DK if you Don't Know the answer to the the question)*

	Yes	No	DK
Active Tuberculosis	☐	☐	☐
Persistent cough greater than a 3 week duration	☐	☐	☐
Cough that produces blood	☐	☐	☐
Been exposed to anyone with tuberculosis	☐	☐	☐

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
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐
Do you drink bottled or filtered water?	☐	☐	☐

If yes, how often? *Circle one:* DAILY / WEEKLY / OCCASIONALLY

Are you currently experiencing dental pain or discomfort?	☐	☐	☐

	Yes	No	DK
Do you have earaches or neck pains?	☐	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Do you brux or grind your teeth?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Do you participate in active recreational activities?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐

Date of your last dental exam:
What was done at that time?

Date of last dental x-rays:

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
Are you now under the care of a physician?	☐	☐	☐

Physician Name: Phone: *Include area code* ( )

Address/City/State/Zip:

Are you in good health?	☐	☐	☐
Has there been any change in your general health within the past year?	☐	☐	☐

If yes, what condition is being treated?

Date of last physical exam:

	Yes	No	DK
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐	☐

If yes, what was the illness or problem?

Are you taking or have you recently taken any prescription or over the counter medicine(s)?	☐	☐	☐

If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements:

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

(Check DK if you Don't Know the answer to the question)

	Yes	No	DK
Do you wear contact lenses?	☐	☐	☐
Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	☐	☐	☐
Date: _____ If yes, have you had any complications? _____			
Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax®, Actonel®, Atelvia, Boniva®, Reclast, Prolia) for osteoporosis or Paget's disease?	☐	☐	☐
Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia®, Zometa®, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?	☐	☐	☐
Date Treatment began: _____			

	Yes	No	DK
Do you use controlled substances (drugs)?	☐	☐	☐
Do you use tobacco (smoking, snuff, chew, bidis)?	☐	☐	☐
If so, how interested are you in stopping? *Circle one:* VERY / SOMEWHAT / NOT INTERESTED			
Do you drink alcoholic beverages?	☐	☐	☐
If yes, how much alcohol did you drink in the last 24 hours? _____			
If yes, how much do you typically drink i n a week? _____			
WOMEN ONLY Are you:			
Pregnant?	☐	☐	☐
Number of weeks: _____			
Taking birth control pills or hormonal replacement?	☐	☐	☐
Nursing?	☐	☐	☐

Allergies. Are you allergic to or have you had a reaction to:
To all **yes** responses, specify type of reaction.

	Yes	No	DK
Local anesthetics _____	☐	☐	☐
Aspirin _____	☐	☐	☐
Penicillin or other antibiotics _____	☐	☐	☐
Barbiturates, sedatives, or sleeping pills _____	☐	☐	☐
Sulfa drugs _____	☐	☐	☐
Codeine or other narcotics _____	☐	☐	☐
Metals _____	☐	☐	☐
Latex (rubber) _____	☐	☐	☐
Iodine _____	☐	☐	☐
Hay fever/seasonal _____	☐	☐	☐
Animals _____	☐	☐	☐
Food _____	☐	☐	☐
Other _____	☐	☐	☐

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

	Yes	No	DK
Artificial (prosthetic) heart valve	☐	☐	☐
Previous infective endocarditis	☐	☐	☐
Damaged valves in transplanted heart	☐	☐	☐
Congenital heart disease (CHD)			
Unrepaired, cyanotic CHD	☐	☐	☐
Repaired (completely) in last 6 months	☐	☐	☐
Repaired CHD with residual defects	☐	☐	☐

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

	Yes	No	DK
Cardiovascular disease	☐	☐	☐
Angina	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Congestive heart failure	☐	☐	☐
Damaged heart valves	☐	☐	☐
Heart attack	☐	☐	☐
Heart murmur	☐	☐	☐
Low blood pressure	☐	☐	☐
High blood pressure	☐	☐	☐
Other congenital heart defects	☐	☐	☐
Mitral valve prolapse	☐	☐	☐
Pacemaker	☐	☐	☐
Rheumatic fever	☐	☐	☐
Rheumatic heart disease	☐	☐	☐
Abnormal bleeding	☐	☐	☐
Anemia	☐	☐	☐
Blood transfusion If yes, date: _____	☐	☐	☐
Hemophilia	☐	☐	☐
AIDS or HIV infection	☐	☐	☐
Arthritis	☐	☐	☐

	Yes	No	DK
Autoimmune disease	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Systemic lupus erythematosus	☐	☐	☐
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐
Tuberculosis	☐	☐	☐
Cancer/Chemotherapy/ Radiation Treatment	☐	☐	☐
Chest pain upon exertion	☐	☐	☐
Chronic pain	☐	☐	☐
Diabetes Type I or II	☐	☐	☐
Eating disorder	☐	☐	☐
Malnutrition	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
G.E. Reflux/persistent heartburn	☐	☐	☐
Ulcers	☐	☐	☐
Thyroid problems	☐	☐	☐
Stroke	☐	☐	☐

	Yes	No	DK
Glaucoma	☐	☐	☐
Hepatitis, jaundice or liver disease	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Neurological disorders If yes, specify: _____	☐	☐	☐
Sleep disorder	☐	☐	☐
Do you snore?	☐	☐	☐
Mental health disorders Specify: _____	☐	☐	☐
Recurrent Infections Type of infection: _____	☐	☐	☐
Kidney problems	☐	☐	☐
Night sweats	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistent swollen glands in neck	☐	☐	☐
Severe headaches/ migraines	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
Excessive urination	☐	☐	☐

	Yes	No	DK
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	☐	☐	☐

Name of physician or dentist making recommendation: _____ Phone: *include area code* ( )

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

Signature of Dentist: _____ Date: _____

FOR COMPLETION BY DENTIST

Comments: _____

Spouse or Responsible Party Information

The following is for: ☐ Patient's Spouse ☐ Person Responsible for Payment

Name _____ Date: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Other

Social Sec #: _____ Date of Birth (MM/DD/YYYY) _____

Telephone: Home: _____ Work: _____ Ext: _____ Cell: _____

e-Mail Address: _____ Street Address: _____

_____

City: _____ State: _____ Zip Code: _____

Employment Information

The following is for: ☐ Patient's Spouse ☐ Person Responsible for Payment

Employer Name: _____ Occupation: _____

e-Mail Address: _____ Telephone: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Primary Insurance Information

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First Mid. Initial

Insured's Date of Birth: (MM/DD/YYYY) _____ ID # _____ Group # _____

Insured's Address: _____

City: _____ State: _____ Zip Code: _____

Insured's Employer Name: _____ Address: _____

City: _____ State: _____ Zip Code: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance Plan Name and Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: _____

Secondary Insurance Information (if applicable)

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First Mid. Initial

Insured's Date of Birth: (MM/DD/YYYY) _____ ID # _____ Group # _____

Insured's Address: _____

City: _____ State: _____ Zip Code: _____

Insured's Employer Name: _____ Address: _____

City: _____ State: _____ Zip Code: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance Plan Name and Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: _____

PATIENTS RESPONSIBILITY FOR X-RAYS AT INITIAL EXAM

We are dedicated to treating our patients with the best possible care. For us to do so and to make accurate and proper diagnoses we need your previous dentists' x-rays and treatment notes.

AN AUTHORIZATION TO RELEASE RECORDS FORM is included in your packet. Please return the completed form to us IMMEDIATELY so we may forward to your previous dentist. A Panorex or Full Mouth Series and Bitewings are necessary for us to properly do an exam. Please have your previous dentist email (preferred method) current x-rays to: frontdesk@didriksendental.com. If your previous dentist does not have email capability have them mail them to us to arrive 3 days prior to your appointment. If x-rays are needed and are not current (within the last year) and not provided to us, we will take them at your initial exam. If you have requested x-rays be set to us please verify we have received them at least 3 days prior to your scheduled appointment. If you keep your appointment and we do not at that time have the necessary x-rays, you acknowledge you are responsible for payment of the x-rays that day.

Signature_____Date_____

IF YOU HAVE DENTAL INSURANCE

Dental Insurance is a contract between YOU and your insurance company. It is only meant to HELP you pay for the cost of your dental care. It is NOT intended to pay for all your dental needs nor should it dictate what your treatment you decide to get. Our office suggests treatment plans based on your dental health needs, NOT on dental health coverage.

We perform the most appropriate procedures using the most appropriate materials. We do not allow insurance companies to dictate your treatment based on the coverage they reimburse nor should you. We also do not allow insurance companies to dictate the level of dental care we provide. We want you to have the best and most current procedures and materials available. Therefore, if there should be a difference in cost arising from what your insurance company did not cover, did not pay or downgraded a procedure you will be responsible and billed the difference resulting in this underpayment. In addition to cash, major credit cards, checks, money orders/cashier checks we do also accept CareCredit. Payment is due for your estimated portion at the time of treatment.

As a courtesy, when possible, our office submits your insurance claims. That is why we need to have your current insurance information and insurance card present at EACH VISIT. If claims are delayed in processing by your insurance company, any balance owed will become your responsibility 30 days subsequent to invoicing.

Thank You for understanding our ultimate concern is for YOU the patient.

Signature_____Date_____

CONSENT FOR SERVICE

As a condition of your treatment by this office payment is due on date of service. If you have insurance...I authorize my insurance company to pay Dr. Pedar Didriksen all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance commissions. I also authorize Dr. Pedar Didriksen to release all information necessary to secure payment of benefits. The undersigned authorizes the Dentist to take x-rays, study models, photographs or any other diagnostic aids deemed appropriate by the Dentist to make a thorough diagnosis of the patient's dental needs. I understand payment is due and payable at the time service are rendered. If I have insurance, I understand it is a contract between me and my insurance carrier and not between the Dentist and the insurance company and that regardless of insurance payment or partial payment, I am still fully responsible for the remaining balance. I also assign all insurance benefits to the Dentist. I understand that any unpaid balance is to be paid in full by me within 30 days of invoicing. I understand that any balance not paid accordingly is subject to a finance charge of 1 ½% per month and I understand I will be responsible for all costs incurred in the collection of these past due amounts.

_____Date_____Relationship to Patient:_____

(Signature of patient, parent, or guardian)

All Gentle Dental
Family and Cosmetic Dentistry
Pedar B. Didriksen DDS
11310 Manklin Creek Rd. Suite 5
Ocean Pines, MD 21811
(410) 208-2900

OFFICE HOURS

Regular Business hours are Monday through Thursday, 8:00 am to 5:00 pm. If you have a dental emergency after normal office hours, please call our office at (410) 208-2900 and you will be able to page Dr. Pedar Didriksen.

STAFF

This practice consists of; Dr. Pedar B. Didriksen, Hygienists, Assistants, and Front Office Coordinators. Our entire staff will be happy to accommodate you anytime during regular business hours and for emergencies after hours.

APPOINTMENTS AND CANCELLATIONS

Your appointment time is reserved especially for you. We ask that if you would need to cancel an appointment that you do so 48 hours in advance to avoid being charged a short notice or no show fee. We also request that if we call you and leave a message to re confirm an appointment that you give us a call back. If for some reason you arrive late for an appointment you may be asked to be rescheduled.

INFORMATION CHANGES

We ask you to advise us of any changes in your dental insurance coverage, medications, medical conditions, employment or contact information as it occurs. Having this current information allows us to serve you more efficiently.

PAYMENT FOR SERVICES

Payment is due at the time your services are performed. We accept all major Credit Cards, Cash, Money Orders, and Cashier's Checks. We also participate with Dental Payment Plans (applications available at our front desk) to assist in paying for your dental care.

WHAT PATIENTS CAN EXPECT FROM US

A high degree of professional skill and quality dentistry with a dedication to your dental health care while maintaining fair fees for the services we provide.

WHAT WE EXPECT FROM OUR PATIENTS

We expect your conscientious effort toward good oral hygiene, scheduling and keeping hygiene appointments, following needed prescribed dental treatments, and also having the needed Diagnostic X-Rays as recommended by the ADA and our office.

Thank you for being a patient of ours and we look forwarded to being your dental provider.

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_____ _____

Signature Date