Welcome to the Dental office of Stephen R. Henry, DDS

Name_____

Address_____

City, State, and Zip Code_____ - _____

Mobile Phone_____

Other Phone (H)_____(W)_____

Email_____

If you have Dental Insurance that you would like us to assist you with:

Name of Dental Plan_____

Subscriber Name if Different from patient_____

Subscriber Date of Birth: _____/____/_____ Group Number: _____

Patient Responsibility and Insurance Authorization:

I authorize my insurance company to pay the dentist all insurance benefits rendered.

I authorize the use of electronic signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure payment of benefits.

I understand that I am financially responsible for all charges whether paid by insurance or not.

Signature:_____

Date:_____

Medical History

Indicate which of the following conditions you have or have had. By checking the box it will indicate a "YES" response, leaving blank will indicate a "NO" response.

- ☐ *Blood Thinner
- ☐ Acid Reflux
- ☐ Arthritis
- ☐ Blood Disease
- ☐ Dizziness
- ☐ Excessive Bleeding
- ☐ Growths
- ☐ Heart Disease
- ☐ HIV+
- ☐ Latex Allergy
- ☐ Nervous Disorders
- ☐ Penicillin Allergy
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ Tuberculosis
- ☐ *No Epi
- ☐ Allergies
- ☐ Artificial Joints
- ☐ Cancer
- ☐ Ear Trouble
- ☐ Eye Disease
- ☐ Hay Fever
- ☐ Heart Murmur
- ☐ HPV
- ☐ Liver Disease
- ☐ Osteoperosis
- ☐ Pregnancy
- ☐ Rheumatism
- ☐ Skin Disease
- ☐ Tumors
- ☐ *Pre Med Required
- ☐ Allergy to Xylocaine
- ☐ Aspirin Allergy
- ☐ Codeine Allergy
- ☐ Emphysema
- ☐ Fainting
- ☐ Head Injuries
- ☐ Hepatitis
- ☐ Jaundice
- ☐ Mental Disorders
- ☐ Other
- ☐ Radiation Treatment
- ☐ Scarlet Fever
- ☐ Stomach Problems
- ☐ Ulcers
- ☐ *Sulfa Allergy
- ☐ Anemia
- ☐ Asthma
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Migraines
- ☐ Pacemaker
- ☐ Respiratory Problems
- ☐ Sens to Epinephrine
- ☐ Stroke
- ☐ Venereal Disease

- ☐ Ever been hospitalized (illness or injury)
- ☐ Taking medication for weight control (ie fen-phen)
- ☐ Subject to frequent headaches
- ☐ FEMALE: Taking birth control pills
- ☐ Presently being treated for any other illnesses
- ☐ Taking dietary supplements
- ☐ A smoker or smoked previously
- ☐ FEMALE: Pregnant

If any conditions or alerts selected above need further clarification, please describe below:

_____

_____

Pre-Med:

_____

_____

Name of your physician and your most recent physical exam:

_____

_____

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect you dental treatment.

_____

_____

Medications:

_____

_____

_____

☐ ***By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes.**

Dental Information

Previous Dentist name and how long have you been a patient there:

_____

_____

Date of most recent dental exam: _____ **Date of most recent dental x-rays:** _____

I routinely see my dentist every:

☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

What is your immediate concern?

_____

_____

Personal History, Check all that apply:

☐ Had an unfavorable dental experience
☐ Had any reactions to local anesthetic
☐ Had any teeth removed
☐ Had complications from past dental treatment
☐ Had/have braces, orthodontic treatment
☐ Had trouble getting numb
☐ Had your bite adjusted

Bite and Jaw Joint, Check all that apply:

☐ You have problems with your jaw joint
☐ You have problems chewing
☐ Your teeth changed in the last 5 years, become shorter, thinner, or worn
☐ Your teeth are crowding or developing spaces
☐ You chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits
☐ You clench your teeth in the daytime or make them sore
☐ You have problems with sleep or wake up with an awareness of your teeth
☐ You wear or have worn a bite appliance

Gum and Bone, Check all that apply:

☐ Gums bleed when brushing or flossing
☐ Treated for gum disease or were told you have lost bone around your teeth
☐ Noticed an unpleasant taste or odor in your mouth
☐ History of periodontal disease in your family
☐ Experienced gum recession
☐ Had any teeth become loose on their own (without injury), or have difficulty eating an apple
☐ Experienced a burning sensation in your mouth

If any of the checked boxes need further explanation, please describe:

_____

_____

_____

_____

Consent for Services and Financial Policy

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

☐ ***By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the AdministrationForm.**

Consent for Internet Communications

I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice web site with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

☐ ***I have read the information above regarding the secured uploading of patient information to the web site for the dental practice, and grant the dental practice permission to securely upload my patient information to the web site.**

Name of the patient, parent, or guardian completing this form: *

_____

_____

Relationship to patient: *

◯ Self ◯ Parent ◯ Guardian ◯ Spouse ◯ Other

Response Date: _____