HELDER COSMETIC & FAMILY
DENTISTRY

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MEDICAL HISTORY

Name:_____ Date: _____

Address (city, state, zip): _____

Phone: (H) _____ (W) _____ (C) _____

E-Mail: _____

Social Security #: _____ Date of Birth _____

Martial Status: ☐ Single ☐ Married

How did you hear about us? _____

Reason for visit:_____

MEDICAL HISTORY

Patient's Physician: _____ Physician's Phone Number: _____

Are you allergic to: ☐ Latex ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Other: _____

Do you require antibiotic pre-medication prior to dental treatment? ☐ YES ☐ NO
If yes, please explain: _____

Do you smoke? ☐ YES ☐ NO If yes, how many packs? How often? _____

Women: Are you pregnant? ☐ YES ☐ NO If so, how many weeks? _____

Have you taken bisphosphonates? (Boniva, Actonel, Fosamax, etc.) ☐ YES ☐ NO If yes, how long? _____

Other important medical info: _____

Please list any medications you are taking:_____

HAVE YOU EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING CONDITIONS?

AIDS:	☐ YES	☐ NO	Asthma:	☐ YES	☐ NO	Heart Disease:	☐ YES	☐ NO
Seizures:	☐ YES	☐ NO	Allergies:	☐ YES	☐ NO	Tuberculosis:	☐ YES	☐ NO
Heart Murmur:	☐ YES	☐ NO	Sinus Problems:	☐ YES	☐ NO	Anemia:	☐ YES	☐ NO
Bleeding Disorder:	☐ YES	☐ NO	Hepatitis:	☐ YES	☐ NO	Stroke:	☐ YES	☐ NO
Arthritis:	☐ YES	☐ NO	Cancer:	☐ YES	☐ NO	Osteoporosis:	☐ YES	☐ NO
TMJ(Jaw) Pain:	☐ YES	☐ NO	Artificial Joints:	☐ YES	☐ NO	Diabetes:	☐ YES	☐ NO
Rheumatic Fever:	☐ YES	☐ NO	Abnormal Blood Pressure:	☐ YES	☐ NO			

DENTAL HISTORY

Last Dental Visit: _____

Do you have tooth pain? ☐ YES ☐ NO
Are your teeth sensitive to hot or cold? ☐ YES ☐ NO
Do your gums bleed? ☐ YES ☐ NO
Any unfinished dental work? ☐ YES ☐ NO
Are any teeth loose? ☐ YES ☐ NO

Patient Signature (parent / guardian if under 18): _____

Doctor's Notes: _____

RESPONSIBLE PARTY INFORMATION (SKIP IF SELF)

Name:_____ Date: _____

Address (city, state, zip): _____

Phone: (H) _____ (W) _____ (C) _____

E-Mail: _____

Social Security #: _____ Date of Birth _____

Relationship to patient: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

DENTAL INSURANCE INFORMATION (IF APPLICABLE)

Policy Holder's Name: _____ Employer Name: _____

Insurance Company Name:_____ Group #: _____

Phone Number: _____ Social Security #: _____ - _____ - _____

Member ID #: _____ Date of Birth:_____

Relationship to patient: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

SECONDARY (IF APPLICABLE)

Policy Holder's Name: _____ Employer Name: _____

Insurance Company Name:_____ Group #: _____

Phone Number: _____ Social Security #: _____ - _____ - _____

Member ID #: _____ Date of Birth:_____

Relationship to patient: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

CONSENT FOR SERVICE

***Please read and initial next to each item

_____ As a condition of your treatment by this office, it is your obligation to inquire about financial arrangement in advance.

_____ All dental services provided without previous financial arrangements, must be paid for at the time the service is provided.

_____ Patients that carry Dental Insurance understand that all dental services provided are charged directly to the Dental Insurance, any fees not covered by Dental Insurance are the responsibility of the patient.

_____ Any unpaid balance exceeding 90 days from the date of service was rendered will be subject to third party collection. I agree to pay All costs associated with the collection of the unpaid balance.

_____ I understand that if an appointment is cancelled less than 48 hours notice there may be a fee equivalent up to 25% of the procedure.

_____ I grant my permission to you or your assignee, to telephone me at home or work to discuss matters related to this form.

_____ I consent and authorize Helder Cosmetic & Family Dentistry/or Dr. Helder to use my radiographs, periodontal Charting, impressions and or clinical photographs for the purpose of communicating with insurances companies, dental providers, the general public or any other lawful purpose. I release and forever discharge any claim, demands or liability on account of such use.

Signature of Patient _____ Date_____

Signature of Responsible Party _____ Relationship to Patient _____