Dental Medical History Form (Version 8/2015)

Patient Name:_____ Birth Date: _____

Although we primarily treat the area in and around the mouth, one's mouth is a part of the entire body. Previous health problems and/or medication could have an important interrelationship with the dentistry the patient will receive. Please answer each of the following questions as completely as possible. Thank you!

Is the patient under a physician's care now?	O Yes O No	If yes _____
Has the patient ever been hospitalized or had a major operation?	O Yes O No	If yes _____
Has the patient had a serious head or neck injury?	O Yes O No	If yes _____
Is the patient taking medications, pills, or drugs?	O Yes O No	If yes _____
Does the patient take, or have taken, Phen-Fen or Redux?	O Yes O No	If yes _____
Is the patient on a special diet?	O Yes O No	If yes _____
Does the patient use tobacco?	O Yes O No	If yes _____
Please list previous hospitalizations/Surgeries/Serious Illnesses?	O Yes O No	If yes _____

Women: Are You...? O Pregnant/Trying to get pregnant O Nursing O Taking Oral Contraceptives

Is the patient allergic to any of the following?

O Aspirin O Penicillin O Codeine O Acrylic
O Metal O Latex O Local Anesthetics
Other Allergy? O Yes O No If yes _____

Does the patient have or had, any of the following?

ADD/ADHD	O Yes O No	Convulsions	O Yes O No	Heart Pacemaker	O Yes O No	Recent Weight Loss	O Yes O No
AIDS/HIV Positive	O Yes O No	Cortisone Medicine	O Yes O No	Heart Trouble/Disease	O Yes O No	Renal Dialysis	O Yes O No
Anaphylaxis	O Yes O No	Diabetes I	O Yes O No	Hemophilia	O Yes O No	Rheumatic Fever	O Yes O No
Anemia	O Yes O No	Diabetes II	O Yes O No	Hepatitis A	O Yes O No	Rheumatism	O Yes O No
Angina	O Yes O No	Down Syndrome	O Yes O No	Hepatitis B or C	O Yes O No	Scarlet Fever	O Yes O No
Anxiety' Disorder	O Yes O No	Drug Addiction	O Yes O No	Herpes	O Yes O No	Shingles	O Yes O No
Arthritis/Gout	O Yes O No	Easily Winded	O Yes O No	High Blood Pressure	O Yes O No	Sickle Cell Disease	O Yes O No
Artificial Heart Valve	O Yes O No	Emphysema	O Yes O No	High Cholesterol	O Yes O No	Sinus Trouble	O Yes O No
Artificial Joint	O Yes O No	*Epilepsy or Seizures	O Yes O No	Hives or Rash	O Yes O No	Special Needs/	
Asperger's	O Yes O No	Excessive Bleeding	O Yes O No	Hypoglycemia	O Yes O No	Developmental Delay	O Yes O No
Asthma	O Yes O No	Excessive Thirst	O Yes O No	Irregular Heartbeat	O Yes O No	Spina Bifida	O Yes O No
Autism	O Yes O No	Fainting Spells/Dizziness	O Yes O No	Kidney Problems	O Yes O No	Stomach/Intestinal Disease	O Yes O No
Blood Disease	O Yes O No	Fetal Alcohol Syndrome	O Yes O No	Leukemia	O Yes O No	Stroke	O Yes O No
Blood Transfusion	O Yes O No	Frequent Cough	O Yes O No	Liver Disease	O Yes O No	Swelling of Limbs	O Yes O No
Breathing Problems	O Yes O No	Frequent Diarrhea	O Yes O No	Low Blood Pressure	O Yes O No	Thyroid Disease	O Yes O No
Bruise Easily	O Yes O No	Frequent Headaches	O Yes O No	Lung Disease	O Yes O No	Tonsillitis	O Yes O No
Cancer	O Yes O No	Genital Herpes	O Yes O No	Mitral Valve Prolapse	O Yes O No	Tuberculosis	O Yes O No
Chemotherapy	O Yes O No	Glaucoma	O Yes O No	Pain in Jaw Joints	O Yes O No	Tumors or Growths	O Yes O No
Chest Pains	O Yes O No	Hay Fever	O Yes O No	Parathyroid Disease	O Yes O No	Ulcers	O Yes O No
Cold Sores/Fever Blisters	O Yes O No	Heart Attack/Failure	O Yes O No	Psychiatric Care	O Yes O No	Venereal Disease	O Yes O No
Congenital Heart Disorder	O Yes O No	*Heart Murmur	O Yes O No	Radiation Treatments	O Yes O No	Yellow Jaundice	O Yes O No

*If Heart Murmur, does the patient require antibiotics prior to dental treatment?	O Yes O No	If yes _____
*If Epilepsy or Seizures, date of last seizure?	O Yes O No	If yes _____
Has the patient ever had any serious illness or condition not listed above?	O Yes O No	If yes _____

Does the patient have any of the following habits?

O Sucking thumb/finger O Suck/Bite Lip O Chew/Bite nails
O Chew hard objects O Grind Teeth O Clench Jaw

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to the patients' health. It is my responsibility to inform the dental office of any changes in the patients' medical status. I also authorize the dental staff to perform the necessary dental services the patient may need.

X_____ _____
Signature of Patient, Parent or Guardian Date

This form has been reviewed with Patient, Parent or Guardian and conditions accurately notated.

X_____ _____
Signature of Providing Dentist Date

Alta Dental Office Policies

By signing this document, you are acknowledging and accepting our office policies

Insurance Patients

Our office accepts assignment of insurance benefits. Our acceptance does not absolve the responsible party of full responsibility of charges for treatment rendered. The estimate provided by our office is to be considered a guideline. We make every effort to be accurate in our estimation of benefits. However, since there is no way to be sure benefits have not been used in other offices or that the policy is in effect at the time of service, this office can make no guarantee of the insurance payment as estimated. Your benefits are between you and your insurance carrier(s). Claims are submitted promptly after treatment is rendered. If your insurance hasn't paid within 45 days of submitted charges the charges will be considered your responsibility and payment in full is expected from the responsible party. We take great pride in helping you achieve the maximum benefit from your insurance. We do that, however, out of courtesy on your behalf. We are always glad to answer your questions and help you in any way we can. Due to HIPAA requirements, we are unable to provide your 2nd insurance with your primary insurance EOB. We therefore need you to forward a copy of your EOB to your 2nd carrier. If you wish to fax the EOB, you may do so at our office if you wish.
I authorize payment to be made directly to ALTA DENTAL for benefits otherwise payable to me, but not to exceed the regular charges for treatment.

Charges and Payments

The patient/responsible party is responsible for total payment for procedures performed at ALTA DENTAL, including any balance not covered by insurance. I understand office policy requires my account to be paid in full each month. If I need to make monthly payments, application for payments needs to be made before the dental treatment begins. All accounts are to be paid in full within 90 days of treatment regardless of insurance. I agree to pay all collection costs.

I understand by not agreeing to this, ALTA DENTAL may refuse to see me and will require that I pay all fees at the time of treatment, including any portion that would be covered by insurance.

Missed Appointments

We reserve the right to charge for missed confirmed appointments at the rate of $25.00 per appointment. Twenty-four (24) hours notice is required to avoid this fee.

Dental Treatment

When a patient receives treatment for any procedure that requires multiple visits (root canal treatment, crowns, bridges, dentures, etc), it is the patient's responsibility to come back to continue or finalize the treatment, regardless if any cancellations were made by our office or the patient.

Dental Records

I understand there will be a $25.00 charge to obtain copies of dental records, including x-rays.

_____ _____ / _____ / _____
Patient Name Date

_____ _____ / _____ / _____
Patient/Guardian Signature Date

HIPAA Notice of Privacy Practices

I have had the full opportunity to read and consider the contents of the Notice of Privacy Practices. I understand that I am giving my permission to your use and disclosure of my protected health information in order to carry out treatment, payment activities, and healthcare operations. I also understand that I have the right to revoke permission.

_____ _____
Name Relationship to Patient

_____ _____ / _____ / _____
Signature Date