

# WELCOME

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us – we will be happy to help.

## 1. Personal Information

Date \_\_\_\_\_

Birthdate \_\_\_\_\_

SS#/SIN \_\_\_\_\_ Email \_\_\_\_\_

Name \_\_\_\_\_

Wishes to be called \_\_\_\_\_

Male  Female  Minor  Single  Married  Divorced  Widowed  Separated

Address \_\_\_\_\_

City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Referred by \_\_\_\_\_

## 2. Responsible Party

Who is responsible for the account?

Name \_\_\_\_\_

Relationship to patient \_\_\_\_\_

Birthdate \_\_\_\_\_ Driver's License # \_\_\_\_\_

SS#/SIN \_\_\_\_\_ E-Mail \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_

Employer \_\_\_\_\_

Occupation \_\_\_\_\_

Work Phone \_\_\_\_\_ Ext. # \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

## 3. Telephone

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Ext. # \_\_\_\_\_

Cell Phone \_\_\_\_\_

Where do you prefer to receive calls?  Home  Work  Cell

In the event of an emergency, who should we contact?

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Work # \_\_\_\_\_ Home # \_\_\_\_\_

## 4. Dental Insurance Information

### Primary Insurance

Name of Insured \_\_\_\_\_  
Relationship to patient \_\_\_\_\_  
Insured's birthday \_\_\_\_\_  
SS#/SIN \_\_\_\_\_  
Employer \_\_\_\_\_  
Date Employed \_\_\_\_\_  
Occupation \_\_\_\_\_  
Insurance Company \_\_\_\_\_  
Group # \_\_\_\_\_  
Policy/ID. # \_\_\_\_\_  
Ins. Co. Address \_\_\_\_\_  
Ins. Co. Phone # \_\_\_\_\_

### Additional Insurance

Name of Insured \_\_\_\_\_  
Relationship to patient \_\_\_\_\_  
Insured's birthday \_\_\_\_\_  
SS#/SIN \_\_\_\_\_  
Employer \_\_\_\_\_  
Date Employed \_\_\_\_\_  
Occupation \_\_\_\_\_  
Insurance Company \_\_\_\_\_  
Group # \_\_\_\_\_  
Policy/ID. # \_\_\_\_\_  
Ins. Co. Address \_\_\_\_\_  
Ins. Co. Phone # \_\_\_\_\_

## 5. Authorization and Release

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 other 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

Signature of patient or parent/guardian if minor

Date

## 6. Financial Arrangements

For your convenience, we offer the following methods of payment.

Please check the option which you prefer.

Payment in full at each appointment.

\_\_\_\_\_ Cash

\_\_\_\_\_ Personal Check

\_\_\_\_\_ Credit Card (Visa, MC, Discover AmExp.)

\_\_\_\_\_ I wish to discuss the dental office's policy.

### Late Charges

If you do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month (if allowed by law). I realize that failure to keep this account current may result in your being unable to provide additional dental services except for dental emergencies or where there is prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount of any future outstanding account balances.

Thank you for filling out this form completely. The information you have provided will help us serve your dental healthcare needs more effectively and efficiently. If you have any questions at anytime, please ask – we are always happy to help.



## **High Plains Dental Office Policies**

### **Welcome to our office.**

We hope to make your visit comfortable and in doing so, we ask a few things of you.

When cancelling an appointment we would appreciate 24 hours notice. We do understand that there are circumstances that do come up such as weather, sickness, and car trouble when you are unable to give us 24 hours notice. When appointments are missed with little or no notice, these scheduled appointment times cannot be filled. As a result, other patients could have been seen during these times that are exclusively reserved for you and your family members. We appreciate your business and would like to work with you to maintain your dental health, but we also have a commitment to see our patients in a timely manner and the need to utilize our appointment times effectively. Our office has a policy of no more than 3 missed appointments without proper notice.

Our financial policy is payment due in full at the time of visit unless you have made arrangements prior to your dental appointment. We collect co-pays and deductibles at the time of visit unless you have made arrangements prior to your dental appointment. We offer 5 payment options in our office: cash, personal check, credit card, Care Credit, and Chase Advantage.

Cell phones may be used in our waiting room area only. All cell phones must be turned off or set to vibrate while in our operatories unless you have prior authorization from the doctor or hygienist.

Our policy on nitrous gas is that we do not administer it while any of our staff are pregnant. We do not treat patients with active cold sores, if you have a cold sore you should call to reschedule appointment for a later date.

I acknowledge that I have read and received a copy of High Plains Dental office policies.

Print Patient Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

669 12<sup>th</sup> St W  
Dickinson, ND 58601  
Phone: 701-483-GRIN (4746)



www.highplainsdentalpc.com  
info@highplainsdentalpc.com  
Fax: 701-483-CARE (2273)

## NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (“HIPAA”), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certification.

I acknowledge that I can receive your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions. I understand that I may withdraw or revoke my permission at any time by notifying High Plains Dental P.C. practice in writing.

In addition to phone calls, how may we confirm your appointments? Please check all that apply.

Text Messages                       Email \_\_\_\_\_

May we leave a message on your answering machine at home or on your cell phone?                       YES                       NO

May we discuss your medical condition with any member of your family?                       YES                       NO

If YES, please name the members allowed:

\_\_\_\_\_

\_\_\_\_\_

Patient Name (Printed): \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### OFFICE USE ONLY

I attempted to obtain the patient’s signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:
-------	-----------	---------

# Health History Form

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: <i>Last First Middle</i>			Home Phone: <i>Include area code</i> ( )	Business/Cell Phone: <i>Include area code</i> ( )	
Address: <i>Mailing address</i>			City:	State:	Zip:
Occupation:			Height:	Weight:	Date of Birth: Sex: M F
SS# or Patient ID:	Emergency Contact:	Relationship:	Home Phone: <i>Include area code</i> ( )	Cell Phone: <i>Include area code</i> ( )	
If you are completing this form for another person, what is your relationship to that person?					
<i>Your Name</i>			<i>Relationship</i>		
<b>Do you have any of the following diseases or problems:</b>			<i>(Check DK if you Don't Know the answer to the the question)</i>		<b>Yes No DK</b>
Active Tuberculosis.....					<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Persistent cough greater than a 3 week duration.....					<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Cough that produces blood.....					<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Been exposed to anyone with tuberculosis.....					<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<b>If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.</b>					

## Dental Information *For the following questions, please mark (X) your responses to the following questions.*

<b>Yes No DK</b>	<b>Yes No DK</b>
Do your gums bleed when you brush or floss?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you have earaches or neck pains?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Are your teeth sensitive to cold, hot, sweets or pressure?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you have any clicking, popping or discomfort in the jaw?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Is your mouth dry?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you brux or grind your teeth?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Have you had any periodontal (gum) treatments?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you have sores or ulcers in your mouth?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Have you ever had orthodontic (braces) treatment?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you wear dentures or partials?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Have you had any problems associated with previous dental treatment?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you participate in active recreational activities?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Is your home water supply fluoridated?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Have you ever had a serious injury to your head or mouth?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Do you drink bottled or filtered water?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Date of your last dental exam:
If yes, how often? <i>Circle one:</i> DAILY / WEEKLY / OCCASIONALLY	What was done at that time?
Are you currently experiencing dental pain or discomfort?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	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.*

<b>Yes No DK</b>	<b>Yes No DK</b>
Are you now under the care of a physician?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Have you had a serious illness, operation or been hospitalized in the past 5 years?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Physician Name: _____ Phone: <i>Include area code</i> ( )	If yes, what was the illness or problem?
Address/City/State/Zip:	Are you taking or have you recently taken any prescription or over the counter medicine(s)?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Are you in good health?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements:
Has there been any change in your general health within the past year?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	_____
If yes, what condition is being treated?	_____
Date of last physical exam:	_____

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

<p><i>(Check DK if you Don't Know the answer to the question)</i></p> <p>Do you wear contact lenses? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p><b>Joint Replacement.</b> Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Date: _____ If yes, have you had any complications? _____</p> <p>Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax®, Actonel®, Atelvia, Boniva®, Reclast, Prolia) for osteoporosis or Paget's disease? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>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? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Date Treatment began: _____</p>	<p style="text-align: right;"><b>Yes No DK</b></p> <p>Do you use controlled substances (drugs)? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Do you use tobacco (smoking, snuff, chew, bidis)? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>If so, how interested are you in stopping? Circle one: VERY / SOMEWHAT / NOT INTERESTED</p> <p>Do you drink alcoholic beverages? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>If yes, how much alcohol did you drink in the last 24 hours? _____</p> <p>If yes, how much do you typically drink in a week? _____</p> <p><b>WOMEN ONLY</b> Are you:</p> <p>Pregnant? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Number of weeks: _____</p> <p>Taking birth control pills or hormonal replacement? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Nursing? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
---	--

<p><b>Allergies.</b> Are you allergic to or have you had a reaction to: To all <b>yes</b> responses, specify type of reaction.</p> <p>Local anesthetics ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Aspirin ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Penicillin or other antibiotics ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Barbiturates, sedatives, or sleeping pills ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Sulfa drugs ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Codeine or other narcotics ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>	<p style="text-align: right;"><b>Yes No DK</b></p> <p>Metals ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Latex (rubber) ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Iodine ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Hay fever/seasonal ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Animals ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Food ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Other ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
--	---

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

<p style="text-align: right;"><b>Yes No DK</b></p> <p>Artificial (prosthetic) heart valve ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Previous infective endocarditis ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Damaged valves in transplanted heart ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Congenital heart disease (CHD)</p> <p style="padding-left: 20px;">Unrepaired, cyanotic CHD ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p style="padding-left: 20px;">Repaired (completely) in last 6 months ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p style="padding-left: 20px;">Repaired CHD with residual defects ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>	<p style="text-align: right;"><b>Yes No DK</b></p> <p>Autoimmune disease ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Rheumatoid arthritis ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Systemic lupus erythematosus ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Asthma ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Bronchitis ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Emphysema ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Sinus trouble ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Tuberculosis ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Cancer/Chemotherapy/ Radiation Treatment ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Chest pain upon exertion ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Chronic pain ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Diabetes Type I or II ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Eating disorder ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Malnutrition ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Gastrointestinal disease ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>G.E. Reflux/persistent heartburn ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Ulcers ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Thyroid problems ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Stroke ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>	<p style="text-align: right;"><b>Yes No DK</b></p> <p>Glaucoma ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Hepatitis, jaundice or liver disease ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Epilepsy ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Fainting spells or seizures ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Neurological disorders ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p style="padding-left: 20px;">If yes, specify: _____</p> <p>Sleep disorder ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Do you snore? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Mental health disorders ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p style="padding-left: 20px;">Specify: _____</p> <p>Recurrent Infections ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p style="padding-left: 20px;">Type of infection: _____</p> <p>Kidney problems ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Night sweats ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Osteoporosis ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Persistent swollen glands in neck ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Severe headaches/migraines ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Severe or rapid weight loss ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Sexually transmitted disease .. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Excessive urination ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
--	---	---

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

<p style="text-align: right;"><b>Yes No DK</b></p> <p>Cardiovascular disease ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Angina ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Arteriosclerosis ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Congestive heart failure ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Damaged heart valves ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Heart attack ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Heart murmur ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Low blood pressure ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>High blood pressure ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Other congenital heart defects ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>	<p style="text-align: right;"><b>Yes No DK</b></p> <p>Mitral valve prolapse ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Pacemaker ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Rheumatic fever ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Rheumatic heart disease ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Abnormal bleeding ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Anemia ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Blood transfusion ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p style="padding-left: 20px;">If yes, date: _____</p> <p>Hemophilia ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>AIDS or HIV infection ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Arthritis ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
---	---

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* ( )

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: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_