Hudson
Dental & Orthodontics

3011 South Lindsay Road, #119 | Gilbert, Arizona 85295 | 480.855.5582 | 480.855.5780 fax

PATIENT HISTORY FORM

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better communicate, the better we can care for you. Our office is committed to meeting or exceeding the standards of infection control mandated by OSH, the CDC and the ADA.

About You

Date: _____

Name: _____ **Birthdate:** ___/___/___ (mm/dd/yyyy)
LAST FIRST MI MR MRS MS DR

Age: _____ **Preferred name:** _____ ☐ **Male** ☐ **Female**

SS#: _____ **Hm#:** _____ **Cell#:** _____ **Wk#:** _____ **Ext:** ____ **DL#:** _____

Email Address: _____ **Home Address:** _____
CITY STATE ZIP

Employer: _____ **Employer Address:** _____

How long there: _____ **Occupation:** _____ **Best time to reach you:** _____

Referred by: _____ **Previous Dentist** _____ **Last Visit Date:** _____

Spouse Information

His/Her Name: _____ **Employer:** _____

SS#: _____ **Wk#:** _____ **Ext:** ____ **Cell#:** _____ **Birthdate:** ___/___/___ (mm/dd/yyyy)

Person Responsible for Account

Name: _____

Wk#: _____ **Ext:** ____ **Hm#:** _____ **DL#:** _____ **SS#:** _____

Billing Address: _____ **Employer:** _____

Primary Dental Insurance

Insurance Co. Name: _____ **Insurance Co. Address:** _____

Insurance Co. Phone: _____ **Group # (Plan, Local or Policy #):** _____

Insured's Name: _____ **Relation:** _____ **Insured's Birthdate:** ___/___/___ (mm/dd/yyyy)

Insured's SS#: _____ **Insured's Employer:** _____

Employer Address: _____

Secondary Dental Insurance

Insurance Co. Name: _____ **Insurance Co. Address:** _____

Insurance Co. Phone: _____ **Group # (Plan, Local or Policy #):** _____

Insured's Name: _____ **Relation:** _____ **Insured's Birthdate:** ___/___/___ (mm/dd/yyyy)

Insured's SS#: _____ **Insured's Employer:** _____

Employer Address: _____

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

His/Her Name: _____ **Relation:** _____

Wk#: _____ **Hm#:** _____ **Cell#:** _____

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Medical History

Do you have a personal physician?: ☐**Yes** ☐**No** **Physician's Name:** _____

Wk#: _____ **Date of last visit:** _____ **Your current health is:** ☐**Good** ☐**Fair** ☐**Poor**

Please Explain: _____

Are you taking any prescription /over-the-counter drugs? ☐**Yes** ☐**No** **Please list each one:** _____

Do you smoke or use tobacco in any other form? ☐**Yes** ☐**No**

For Women:

Are you taking birth control pills? ☐**Yes** ☐**No** **Are you pregnant?** ☐**Yes** ☐**No** **Are you nursing?** ☐**Yes** ☐**No**

Have you had any of the following disease or medical problems? *(Please circle option that applies)*

Y N Anemia/Radiation Treatment	Y N Fever Blisters/Herpes	Y N Psychiatric Problems
Y N Artificial Bones/Joints/Valves	Y N Heart Attack/Stroke	Y N Rheumatic/Scarlet Fever
Y N Arthritis	Y N Heart Murmur	Y N Severe/Frequent Headaches
Y N Blood Transfusion	Y N Heart Surgery/Pacemaker	Y N Shingles
Y N Cancer/Chemotherapy	Y N Hemophilia/Abnormal Bleeding	Y N Sickle Cell Disease/Traits
Y N Congenital Heart Defect	Y N Hepatitis	Y N Sinus Problems
Y N Diabetes	Y N Hig/Low Blood Pressure	Y N Tuberculosis (TB)
Y N Difficulty Breathing	Y N HIV+/Aids	Y N Ulcers/Colitis
Y N Drug/Alcohol Abuse	Y N Hospitalized for Any Reason	Y N Venereal Disease
Y N Emphysema/Glaucoma	Y N Kidney Problems	
Y N Epilepsy/Seizures/Fainting Spells	Y N Mital Valve Prolapse	

Please list any serious medical condition(s) that you have ever had: _____

_____

Are you allergic to any of the following?

Y N Asprin	Y N Erythromycin	Y N Penicillin
Y N Codeine	Y N Jewelry/Metals	Y N Tetracycline
Y N Dental Anesthetics	Y N Latex	Y N Other

Please list any drugs/materials that you are allergic to: _____

_____

Dental History

Why have you come to the dentist today? _____

Do you require antibiotics before dental treatment? ☐**Yes** ☐**No** **Are you currently in pain?** ☐**Yes** ☐**No**

Have you ever had a serious/difficult problem associated with any previous dental work? ☐**Yes** ☐**No**

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? ☐**Yes** ☐**No**

Your current dental health is: ☐**Good** ☐**Fair** ☐**Poor** **Do you like your smile?** ☐**Yes** ☐**No** **Do your gums bleed?** ☐**Yes** ☐**No**

How many times a week do you floss? _____ **a day do you brush?** _____ **Type of bristles?** ☐**Hard** ☐**Medium** ☐**Soft**

Have you ever taken Phen-Fen? *(Also known as Redux or Pondimin)* ☐**Yes** ☐**No** **If so, when?** _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Signature: _____ **Date:** _____

Payment is due in full at the time of treatment unless prior arrangements have been approved.

OFFICE USE ONLY

I verbally reviewed the medical /dental information above with the patient named herein. **Initials:** _____ **Date:** _____

Doctor's Comments: _____

_____

1. Date: _____ **Comments:** _____ **Signature:** _____

1. Date: _____ **Comments:** _____ **Signature:** _____

1. Date: _____ **Comments:** _____ **Signature:** _____

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Financial Policy

In order to establish optimal relations with our patient and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the policies of our office.

Payment is required for all services at the time they are rendered and in some instances prior to the appointment date. For your convenience, we accept: cash, debit, Visa, Master Card, American Express, Discover and Care Credit.

Cash paying or non-insured patients receive a 10% discount applied at the time of your appointment when services are rendered.

If you are enrolled in a dental plan or insurance with which we are participating providers we will bill that dental plan for you. For those patients, applicable co-payments, co-insurances and deductibles will be collected **at the time of service**. In the event the dental plan or insurance **DOES NOT** render payment for the dental treatment, **YOU ARE RESPONSIBLE** to pay the balance in full.

In the case of dual insurance, or multiple insurances, we will make every effort to maximize your benefits. We can only ESTIMATE what each will do. If you require further investigation, we recommend that you contact each one directly. As a provider, we can only assist you with your benefits. **WE MAKE NO GUARANTEE** what your insurance will or will not do.

We will send you a statement if the dental insurance does not pay the estimated amount for the services rendered. Interest of 22% APR may be applied to all balances left unpaid until there is a zero balance. Should your unpaid account go to collections, the patient/guarantor of the account will be charged for all fees incurred, which is approximately 50%.

The financial policy of Hudson Dental & Orthodontics has been fully explained to me and I acknowledge full responsibility for ALL charges incurred, regardless of possible insurance coverage. I further agree to pay all collection costs, attorney fees, and any other cost that may be insured to enforce collection of any amount outstanding.

_____ _____

Signature of Patient/Guarantor Date

Cancellation Policy:
We require a minimum of 24 hour notice prior to a scheduled appointment time. If an appointment is canceled with less than 24 hours notice a fee of $50.00 will be applied. If an appointment is canceled multiple times, we require pre-payment for ALL future scheduled appointments.

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NOTICE OF PRIVACY PRACTICES – ACKNOWLEGMENT AND CONSENT

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

This Notice of Privacy Practices tells you how we may use and share your health records. **PLEASE READ IT.**

- We will use and share you health records to treat you and to bill for services we provide.
- We will use and share you health records as required by law.
- We will use and share you health records to those you give us consent to send on your behalf

All the ways we may use and share health records are explained in more detail in the Notice of Privacy Practices.

You have the following rights with respect to your health records:

- You have the right to look at and receive a copy of your health records.
- You have the right to receive a list of whom we have given your health records to.
- You have the right to as us to correct a mistake in your health records.
- You have the right to ask that we not use or share your health records with anyone.
- You have the right to ask us to change the way we contact you.

All of these rights are explained in more detail in the Notice of Privacy Practices

_____ _____

Signature of Patient/Legal Guardian Date