

PATIENT NAME \_\_\_\_\_ TODAY'S DATE \_\_\_\_\_  
 HOME ADDRESS \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_  
 \_\_\_\_\_ HOME PHONE \_\_\_\_\_  
 BUSINESS ADDRESS \_\_\_\_\_ BUSINESS PHONE \_\_\_\_\_  
 \_\_\_\_\_ SOC. SEC. NO. \_\_\_\_\_

## PATIENT MEDICAL HISTORY

PHYSICIAN \_\_\_\_\_ OFFICE PHONE \_\_\_\_\_ DATE OF LAST EXAM \_\_\_\_\_

- |                                                                                                                           | YES                      | NO                       |                                                                                            |                          |                          |
|---------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|--------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| 1. ARE YOU UNDER MEDICAL TREATMENT NOW?                                                                                   | <input type="checkbox"/> | <input type="checkbox"/> | 7. ARE YOU ALLERGIC TO OR HAVE YOU HAD ANY REACTIONS TO ANY DRUGS? IF YES, PLEASE SPECIFY. |                          |                          |
| 2. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS?                                         | <input type="checkbox"/> | <input type="checkbox"/> | _____                                                                                      |                          |                          |
| 3. ARE YOU TAKING ANY MEDICATION(S) INCLUDING NON-PRESCRIPTION MEDICINE? IF YES, WHAT MEDICATION(S) ARE YOU TAKING? _____ | <input type="checkbox"/> | <input type="checkbox"/> | _____                                                                                      |                          |                          |
| 4. DO YOU USE TOBACCO?                                                                                                    | <input type="checkbox"/> | <input type="checkbox"/> | 8. WHEN WAS YOUR LAST COMPLETE PHYSICAL? _____                                             |                          |                          |
| 5. DO YOU USE ALCOHOL, COCAINE OR OTHER DRUGS?                                                                            | <input type="checkbox"/> | <input type="checkbox"/> | 9. WOMEN ONLY:                                                                             | YES                      | NO                       |
| 6. ARE YOU WEARING CONTACT LENSES?                                                                                        | <input type="checkbox"/> | <input type="checkbox"/> | A) ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT?                                          | <input type="checkbox"/> | <input type="checkbox"/> |
|                                                                                                                           |                          |                          | B) ARE YOU NURSING?                                                                        | <input type="checkbox"/> | <input type="checkbox"/> |
|                                                                                                                           |                          |                          | C) ARE YOU TAKING BIRTH CONTROL PILLS?                                                     | <input type="checkbox"/> | <input type="checkbox"/> |

10. PLEASE INDICATE WHICH OF THE FOLLOWING APPLIES TO YOU. CHECK ONLY IF ANSWER IS YES.

- |                                                 |                                                       |                                                |                                                       |
|-------------------------------------------------|-------------------------------------------------------|------------------------------------------------|-------------------------------------------------------|
| <input type="checkbox"/> HIGH BLOOD PRESSURE    | <input type="checkbox"/> HEART DISEASE                | <input type="checkbox"/> CHEST PAINS           | <input type="checkbox"/> KIDNEY DISEASES              |
| <input type="checkbox"/> HEART ATTACK           | <input type="checkbox"/> CARDIAC PACEMAKER            | <input type="checkbox"/> EASILY WINDED         | <input type="checkbox"/> AIDS OR HIV INFECTION        |
| <input type="checkbox"/> RHEUMATIC FEVER        | <input type="checkbox"/> HEART MURMUR                 | <input type="checkbox"/> STROKE                | <input type="checkbox"/> THYROID PROBLEM              |
| <input type="checkbox"/> SWOLLEN ANKLES         | <input type="checkbox"/> ANGINA                       | <input type="checkbox"/> HAY FEVER / ALLERGIES | <input type="checkbox"/> HEPATITIS / JAUNDICE         |
| <input type="checkbox"/> FAINTING / SEIZURES    | <input type="checkbox"/> FREQUENTLY TIRED             | <input type="checkbox"/> TUBERCULOSIS          | <input type="checkbox"/> SEXUALLY TRANSMITTED DISEASE |
| <input type="checkbox"/> ASTHMA                 | <input type="checkbox"/> ANEMIA                       | <input type="checkbox"/> RADIATION THERAPY     | <input type="checkbox"/> STOMACH TROUBLES / ULCERS    |
| <input type="checkbox"/> LOW BLOOD PRESSURE     | <input type="checkbox"/> EMPHYSEMA                    | <input type="checkbox"/> GLAUCOMA              | <input type="checkbox"/> RESPIRATORY PROBLEMS         |
| <input type="checkbox"/> EPILEPSY / CONVULSIONS | <input type="checkbox"/> CANCER                       | <input type="checkbox"/> RECENT WEIGHT LOSS    | <input type="checkbox"/> OTHER _____                  |
| <input type="checkbox"/> LEUKEMIA               | <input type="checkbox"/> ARTHRITIS                    | <input type="checkbox"/> LIVER DISEASE         | _____                                                 |
| <input type="checkbox"/> DIABETES               | <input type="checkbox"/> JOINT REPLACEMENT OR IMPLANT | <input type="checkbox"/> HEART TROUBLE         | _____                                                 |

## COMMENTS

## PATIENT DENTAL HISTORY

PLEASE INDICATE WHICH OF THE FOLLOWING APPLIES TO YOU. CHECK ONLY IF ANSWER IS YES.

- |                                                                         |                          |                                                                                 |                          |
|-------------------------------------------------------------------------|--------------------------|---------------------------------------------------------------------------------|--------------------------|
| 1. DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING?                       | <input type="checkbox"/> | 8. DO YOU HAVE FREQUENT HEADACHES?                                              | <input type="checkbox"/> |
| 2. ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS?               | <input type="checkbox"/> | 9. DO YOU CLENCH OR GRIND YOUR TEETH?                                           | <input type="checkbox"/> |
| 3. ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/FOODS?             | <input type="checkbox"/> | 10. DO YOU BITE YOUR LIPS OR CHEEKS, FREQUENTLY?                                | <input type="checkbox"/> |
| 4. DO YOU FEEL PAIN TO ANY OF YOUR TEETH?                               | <input type="checkbox"/> | 11. HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS IN THE PAST?                    | <input type="checkbox"/> |
| 5. DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH?                | <input type="checkbox"/> | 12. HAVE YOU HAD ANY ORTHODONTIC WORK?                                          | <input type="checkbox"/> |
| 6. HAVE YOU HAD ANY HEAD, NECK OR JAW INJURIES?                         | <input type="checkbox"/> | 13. HAVE YOU EVER HAD PROLONGED BLEEDING FOLLOWING EXTRACTIONS?                 | <input type="checkbox"/> |
| 7. HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING PROBLEMS IN YOUR JAW? |                          | 14. HAVE YOU EVER HAD INSTRUCTION ON THE CORRECT METHOD OF BRUSHING YOUR TEETH? | <input type="checkbox"/> |
| A) CLICKING?                                                            | <input type="checkbox"/> | 15. HAVE YOU EVER HAD INSTRUCTIONS ON THE CARE OF YOUR GUMS?                    | <input type="checkbox"/> |
| B) PAIN (JOINT, EAR, SIDE OF FACE)?                                     | <input type="checkbox"/> |                                                                                 |                          |
| C) DIFFICULTY IN OPENING OR CLOSING?                                    | <input type="checkbox"/> |                                                                                 |                          |
| D) DIFFICULTY IN CHEWING?                                               | <input type="checkbox"/> |                                                                                 |                          |

I certify that I have read and understand the above information, to the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

**X**

\_\_\_\_\_  
 PATIENT, PARENT OR GUARDIAN

\_\_\_\_\_  
 DATE

# PATIENT INFORMATION

CONFIDENTIAL

PATIENT # \_\_\_\_\_

(PLEASE PRINT)

DATE \_\_\_\_\_

NAME \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ HOME PHONE \_\_\_\_\_  
FIRST MI LAST

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

CHECK APPROPRIATE BOX:  MINOR  SINGLE  MARRIED  DIVORCED  WIDOWED  SEPARATED

PATIENT'S OR PARENT'S EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_

BUSINESS ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

SPOUSE OR PARENT'S NAME \_\_\_\_\_ EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_

IF PATIENT IS A STUDENT, NAME OF SCHOOL/COLLEGE \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_

PERSON TO CONTACT IN CASE OF AN EMERGENCY \_\_\_\_\_ PHONE \_\_\_\_\_

WHOM MAY WE THANK FOR REFERRING YOU? \_\_\_\_\_

# RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_

ADDRESS \_\_\_\_\_ HOME PHONE \_\_\_\_\_

SOCIAL SECURITY NUMBER \_\_\_\_\_

EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_

ADDRESS \_\_\_\_\_

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE?  YES  NO

# INSURANCE INFORMATION

NAME OF INSURED \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_

BIRTHDATE \_\_\_\_\_ SOCIAL SECURITY NUMBER \_\_\_\_\_ DATE EMPLOYED \_\_\_\_\_

NAME OF EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_

ADDRESS OF EMPLOYER \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

INSURANCE COMPANY \_\_\_\_\_ GROUP # \_\_\_\_\_ UNION OR LOCAL # \_\_\_\_\_

INS. CO. ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOW MUCH IS YOUR DEDUCTIBLE? \_\_\_\_\_ HOW MUCH HAVE YOU USED? \_\_\_\_\_ MAX. ANNUAL BENEFIT? \_\_\_\_\_

**DO YOU HAVE ANY ADDITIONAL INSURANCE?  YES  NO IF YES, COMPLETE THE FOLLOWING:**

NAME OF INSURED \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_

BIRTHDATE \_\_\_\_\_ SOCIAL SECURITY NUMBER \_\_\_\_\_ DATE EMPLOYED \_\_\_\_\_

NAME OF EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_

ADDRESS OF EMPLOYER \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

INSURANCE COMPANY \_\_\_\_\_ GROUP # \_\_\_\_\_ UNION OR LOCAL # \_\_\_\_\_

INS. CO. ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOW MUCH IS YOUR DEDUCTIBLE? \_\_\_\_\_ HOW MUCH HAVE YOU USED? \_\_\_\_\_ MAX. ANNUAL BENEFIT? \_\_\_\_\_

**X**  
SIGNATURE OF PATIENT OR PARENT IF MINOR \_\_\_\_\_

# PATIENT'S DENTAL HISTORY

PATIENT'S NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

REASON FOR THIS VISIT \_\_\_\_\_

WHEN WAS YOUR LAST DENTAL VISIT \_\_\_\_\_ WHAT WAS DONE THEN \_\_\_\_\_

HOW OFTEN DID YOU VISIT THE DENTIST BEFORE THEN \_\_\_\_\_

PREVIOUS DENTIST (NAME AND LOCATION) \_\_\_\_\_

HAVE YOU HAD A COMPLETE SERIES OF DENTAL FILMS (X-RAYS) TAKEN WHEN/WHERE \_\_\_\_\_

HOW OFTEN DO YOU BRUSH YOUR TEETH \_\_\_\_\_ HOW OFTEN DO YOU FLOSS YOUR TEETH \_\_\_\_\_

IS YOUR DRINKING WATER FLUORIDATED \_\_\_\_\_

	YES	NO		YES	NO
DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING.....	<input type="checkbox"/>	<input type="checkbox"/>	DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY	<input type="checkbox"/>	<input type="checkbox"/>
ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS.....	<input type="checkbox"/>	<input type="checkbox"/>	HAVE YOU NOTICED ANY LOOSENING OF YOUR TEETH.....	<input type="checkbox"/>	<input type="checkbox"/>
ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/FOODS.....	<input type="checkbox"/>	<input type="checkbox"/>	DOES FOOD TEND TO BECOME CAUGHT BETWEEN YOUR TEETH.....	<input type="checkbox"/>	<input type="checkbox"/>
DO YOU FEEL PAIN TO ANY OF YOUR TEETH.....	<input type="checkbox"/>	<input type="checkbox"/>	HAVE YOU EVER HAD PERIODONTAL TREATMENT (GUMS).....	<input type="checkbox"/>	<input type="checkbox"/>
DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH.....	<input type="checkbox"/>	<input type="checkbox"/>	EVER WORN A BITE PLATE OR OTHER APPLIANCE..	<input type="checkbox"/>	<input type="checkbox"/>
HAVE YOU HAD ANY HEAD, NECK OR JAW INJURIES	<input type="checkbox"/>	<input type="checkbox"/>	HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS IN THE PAST.....	<input type="checkbox"/>	<input type="checkbox"/>
HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING PROBLEMS IN YOUR JAW?			HAVE YOU EVER HAD ANY PROLONGED BLEEDING FOLLOWING EXTRACTIONS.....	<input type="checkbox"/>	<input type="checkbox"/>
CLICKING.....	<input type="checkbox"/>	<input type="checkbox"/>	DO YOU WEAR DENTURES OR PARTIALS.....	<input type="checkbox"/>	<input type="checkbox"/>
PAIN (JOINT, EAR, SIDE OF FACE).....	<input type="checkbox"/>	<input type="checkbox"/>	IF YES, DATE OF PLACEMENT _____		
DIFFICULTY IN OPENING OR CLOSING.....	<input type="checkbox"/>	<input type="checkbox"/>	HAVE YOU EVER RECEIVED ORAL HYGIENE INSTRUCTIONS REGARDING THE CARE OF YOUR TEETH AND GUMS.....	<input type="checkbox"/>	<input type="checkbox"/>
DIFFICULTY IN CHEWING.....	<input type="checkbox"/>	<input type="checkbox"/>			
DO YOU HAVE FREQUENT HEADACHES.....	<input type="checkbox"/>	<input type="checkbox"/>			
DO YOU CLENCH OR GRIND YOUR TEETH.....	<input type="checkbox"/>	<input type="checkbox"/>			

IF YOU COULD CHANGE ANYTHING ABOUT YOUR SMILE, WHAT WOULD YOU CHANGE? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**AUTHORIZATION AND RELEASE**  
I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION TO THE BEST OF MY KNOWLEDGE. THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. 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 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** \_\_\_\_\_ DATE \_\_\_\_\_  
SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR

DOCTOR'S COMMENTS \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

Patterson 1-800-637-1140 #70515775

PATIENT'S NUMBER \_\_\_\_\_

# PATIENT'S MEDICAL HISTORY

PATIENT'S NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

ALTHOUGH DENTAL PERSONNEL PRIMARILY TREAT THE AREA IN AND AROUND YOUR MOUTH, YOUR MOUTH IS A PART OF YOUR ENTIRE BODY. HEALTH PROBLEMS THAT YOU MAY HAVE, OR MEDICATION THAT YOU MAY BE TAKING, COULD HAVE AN IMPORTANT INTERRELATIONSHIP WITH THE DENTISTRY THAT YOU WILL BE RECEIVING. THANK YOU FOR ANSWERING THE FOLLOWING QUESTIONS.

	YES	NO		YES	NO
1. ARE YOU IN GOOD HEALTH.....	<input type="checkbox"/>	<input type="checkbox"/>	12. HAVE YOU EVER TAKEN FEN-PHEN/REDUX.....	<input type="checkbox"/>	<input type="checkbox"/>
2. HAVE THERE BEEN ANY CHANGES IN YOUR GENERAL HEALTH WITHIN THE PAST YEAR.....	<input type="checkbox"/>	<input type="checkbox"/>	13. HAVE YOU EVER TAKEN FOSAMAX, BONIVA, ACTONEL OR ANY CANCER MEDICATIONS CONTAINING BISPHOSPHONATES.....	<input type="checkbox"/>	<input type="checkbox"/>
3. DATE OF YOUR LAST PHYSICAL EXAM: _____			14. HAVE YOU TAKEN VIAGRA, REVATIO, CIALIS OR LEVITRA IN THE LAST 24 HOURS.....	<input type="checkbox"/>	<input type="checkbox"/>
4. PHYSICIAN'S NAME _____ ADDRESS _____ PHONE NO. _____			15. DO YOU USE TOBACCO.....	<input type="checkbox"/>	<input type="checkbox"/>
5. ARE YOU NOW UNDER THE CARE OF A PHYSICIAN.....	<input type="checkbox"/>	<input type="checkbox"/>	16. DO YOU OR HAVE YOU USED CONTROLLED SUBSTANCES.....	<input type="checkbox"/>	<input type="checkbox"/>
6. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS... PLEASE EXPLAIN. _____	<input type="checkbox"/>	<input type="checkbox"/>	17. ARE YOU WEARING CONTACT LENSES.....	<input type="checkbox"/>	<input type="checkbox"/>
7. ARE YOU TAKING ANY MEDICINE(S) INCLUDING NON-PRESCRIPTION MEDICINE... IF YES, WHAT MEDICINE(S) ARE YOU TAKING _____	<input type="checkbox"/>	<input type="checkbox"/>	18. DO YOU HAVE A PERSISTENT COUGH OR THROAT CLEARING NOT ASSOCIATED WITH A KNOWN ILLNESS (LASTING MORE THAN 3 WEEKS).....	<input type="checkbox"/>	<input type="checkbox"/>
8. HAVE YOU HAD ANY ABNORMAL BLEEDING...	<input type="checkbox"/>	<input type="checkbox"/>	19. DO YOU HAVE ANY DISEASE, CONDITION OR PROBLEM NOT LISTED ABOVE THAT YOU THINK I SHOULD KNOW ABOUT.....	<input type="checkbox"/>	<input type="checkbox"/>
9. DO YOU BRUISE EASILY.....	<input type="checkbox"/>	<input type="checkbox"/>	<b>WOMEN ONLY:</b>		
10. HAVE YOU EVER REQUIRED A BLOOD TRANSFUSION	<input type="checkbox"/>	<input type="checkbox"/>	ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT...	<input type="checkbox"/>	<input type="checkbox"/>
11. HAVE YOU HAD A RECENT WEIGHT LOSS.....	<input type="checkbox"/>	<input type="checkbox"/>	ARE YOU NURSING.....	<input type="checkbox"/>	<input type="checkbox"/>
			ARE YOU TAKING BIRTH CONTROL PILLS.....	<input type="checkbox"/>	<input type="checkbox"/>

	YES	NO		YES	NO
<b>ARE YOU ALLERGIC TO OR HAVE YOU HAD REACTIONS TO:</b>			HIVES OR SKIN RASH.....	<input type="checkbox"/>	<input type="checkbox"/>
LOCAL ANESTHETICS LIKE NOVOCAINE.....	<input type="checkbox"/>	<input type="checkbox"/>	FAINTING OR DIZZY SPELLS.....	<input type="checkbox"/>	<input type="checkbox"/>
PENICILLIN OR OTHER ANTIBIOTICS.....	<input type="checkbox"/>	<input type="checkbox"/>	DIABETES.....	<input type="checkbox"/>	<input type="checkbox"/>
SULFA DRUGS.....	<input type="checkbox"/>	<input type="checkbox"/>	AIDS OR HIV INFECTION.....	<input type="checkbox"/>	<input type="checkbox"/>
BARBITURATES, SEDATIVES OR SLEEPING PILLS...	<input type="checkbox"/>	<input type="checkbox"/>	THYROID PROBLEMS.....	<input type="checkbox"/>	<input type="checkbox"/>
ASPIRIN.....	<input type="checkbox"/>	<input type="checkbox"/>	ALLERGIES.....	<input type="checkbox"/>	<input type="checkbox"/>
IODINE.....	<input type="checkbox"/>	<input type="checkbox"/>	ARTHRITIS OR RHEUMATISM.....	<input type="checkbox"/>	<input type="checkbox"/>
ANY METALS (E.G., NICKEL, MERCURY, ETC.).....	<input type="checkbox"/>	<input type="checkbox"/>	JOINT REPLACEMENT OR IMPLANT.....	<input type="checkbox"/>	<input type="checkbox"/>
LATEX / RUBBER.....	<input type="checkbox"/>	<input type="checkbox"/>	STOMACH ULCER.....	<input type="checkbox"/>	<input type="checkbox"/>
OTHER (PLEASE LIST) _____			KIDNEY TROUBLE.....	<input type="checkbox"/>	<input type="checkbox"/>
<b>DO YOU HAVE OR HAVE YOU EVER HAD THE FOLLOWING:</b>			TUBERCULOSIS.....	<input type="checkbox"/>	<input type="checkbox"/>
RHEUMATIC HEART DISEASE OR RHEUMATIC FEVER	<input type="checkbox"/>	<input type="checkbox"/>	PERSISTENT COUGH.....	<input type="checkbox"/>	<input type="checkbox"/>
SCARLET FEVER.....	<input type="checkbox"/>	<input type="checkbox"/>	COUGH THAT PRODUCES BLOOD.....	<input type="checkbox"/>	<input type="checkbox"/>
HEART DEFECT OR HEART MURMUR.....	<input type="checkbox"/>	<input type="checkbox"/>	CHEMOTHERAPY (CANCER, LEUKEMIA).....	<input type="checkbox"/>	<input type="checkbox"/>
HEART TROUBLE, HEART ATTACK, OR ANGINA.....	<input type="checkbox"/>	<input type="checkbox"/>	SEXUALLY TRANSMITTED DISEASE.....	<input type="checkbox"/>	<input type="checkbox"/>
CHEST PAIN.....	<input type="checkbox"/>	<input type="checkbox"/>	EPILEPSY OR SEIZURES.....	<input type="checkbox"/>	<input type="checkbox"/>
SHORTNESS OF BREATH.....	<input type="checkbox"/>	<input type="checkbox"/>	ANEMIA.....	<input type="checkbox"/>	<input type="checkbox"/>
PACEMAKER.....	<input type="checkbox"/>	<input type="checkbox"/>	GLAUCOMA.....	<input type="checkbox"/>	<input type="checkbox"/>
HEART SURGERY.....	<input type="checkbox"/>	<input type="checkbox"/>	NERVOUSNESS.....	<input type="checkbox"/>	<input type="checkbox"/>
HIGH/LOW BLOOD PRESSURE.....	<input type="checkbox"/>	<input type="checkbox"/>	TONSILLITIS.....	<input type="checkbox"/>	<input type="checkbox"/>
CONGENITAL HEART PROBLEM.....	<input type="checkbox"/>	<input type="checkbox"/>	TUMORS.....	<input type="checkbox"/>	<input type="checkbox"/>
SWELLING OF FEET, ANKLES, HANDS.....	<input type="checkbox"/>	<input type="checkbox"/>	MENTAL HEALTH CARE.....	<input type="checkbox"/>	<input type="checkbox"/>
HEPATITIS, JAUNDICE OR LIVER DISEASE.....	<input type="checkbox"/>	<input type="checkbox"/>	BACK PROBLEMS.....	<input type="checkbox"/>	<input type="checkbox"/>
STROKE.....	<input type="checkbox"/>	<input type="checkbox"/>	CHEMICAL DEPENDENCY.....	<input type="checkbox"/>	<input type="checkbox"/>
SINUS TROUBLE.....	<input type="checkbox"/>	<input type="checkbox"/>	MITRAL VALVE PROLAPSE.....	<input type="checkbox"/>	<input type="checkbox"/>
LUNG OR BREATHING PROBLEMS.....	<input type="checkbox"/>	<input type="checkbox"/>	CORTISONE TREATMENT.....	<input type="checkbox"/>	<input type="checkbox"/>
ASTHMA OR HAY FEVER.....	<input type="checkbox"/>	<input type="checkbox"/>	COLD SORES/FEVER BLISTERS.....	<input type="checkbox"/>	<input type="checkbox"/>
			HYPOGLYCEMIA.....	<input type="checkbox"/>	<input type="checkbox"/>
			EATING DISORDERS.....	<input type="checkbox"/>	<input type="checkbox"/>

PATIENT'S NUMBER \_\_\_\_\_

Henrik L. Anderson, DDS

269 Peninsula Farm Road, Suites A, B & C  
Arnold, Maryland 21012

## **Financial and Insurance Policy**

### **Payment for Service:**

Patients must pay all financial obligations on the date of service.

Patients covered by insurance accepted in our office must assign benefits to Dr. Henrik L. Anderson. We will provide an estimate of your co-pay and collect the portion at the time of the appointment. We estimate your responsibility as closely as possible, however until we receive correspondence and/or payment from your insurance company, it is just an estimate. **Ultimately, the responsibility lies with you, the patient.** We do our best to obtain payment from the insurance company; however, if your claim is not processed and paid within 90 days, you will be responsible for the balance in full. A Billing statement will be sent out which you will be responsible to remit payment within two weeks of the statement date.

We accept cash, checks, Visa, MasterCard, Discover and American Express. At this time, we do not offer "in house" payment plans. However, we do offer Care Credit, an outside healthcare financing program that offers interest-free payment plans upon approval.

### **Broken and Failed Appointments:**

As a courtesy, you will receive a call, text, and/or email to remind you of your scheduled appointment. If you need to cancel your appointment, please notify us at least 24 hours in advance. Cancellations with less than 24 hour notice will incur a fee of \$50.00.

**Dr. Anderson and the staff believe that clear communication of, and agreement or patient responsibility is an integral part of caring for our patients.**

I have read the policy and agree to accept terms stated above.

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Patient/Responsible Party \_\_\_\_\_

**NOTICES OF PRIVACY PRACTICES ACKNOWLEDGEMENT**  
**HENRIK L. ANDERSON, DDS**  
**269 PENINSULA FARM RD. SUITES A, B & C**  
**ARNOLD, MARYLAND 21012**

I understand that, under the Health Portability & Accountability Act of 1996 (HIPPA), 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 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 certifications.

I have received, read, and understand 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 healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

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

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

(name of authorized person)

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

If you would like anyone other than yourself to pick up written prescriptions, referral forms, or to receive your lab results, please sign below and list the persons to receive the above information.

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

Name of Persons: \_\_\_\_\_

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

## Authorization to Release & Discuss Dental Information

The HIPPA privacy law requires that we are only authorized to communicate with patients themselves, Guardians, insurance providers and primary care physicians, unless we have authorization in writing by the patient to communicate with others on their behalf. Please provide all family members or friends you want us to be able to speak with. **Spouses are not automatically included; their names must be explicitly stated below.** You may opt out by checking the "Do NOT Release Information" box below.

I give the following names person(s) authorization to take messages or speak with the office of Henrik L. Anderson DDS, on my behalf regarding **(please check all items authorized)**.

Name of authorized person(s): \_\_\_\_\_ Relationship \_\_\_\_\_  
Phone Number \_\_\_\_\_  
 Appointments,  Financial,  Dental Treatment,  Insurance  Other (explain) \_\_\_\_\_

Name of authorized person(s): \_\_\_\_\_ Relationship \_\_\_\_\_  
Phone Number \_\_\_\_\_  
 Appointments,  Financial,  Dental Treatment,  Insurance  Other (explain) \_\_\_\_\_

Name of authorized person(s): \_\_\_\_\_ Relationship \_\_\_\_\_  
Phone Number \_\_\_\_\_  
 Appointments,  Financial,  Dental Treatment,  Insurance  Other (explain) \_\_\_\_\_

Name of authorized person(s): \_\_\_\_\_ Relationship \_\_\_\_\_  
Phone Number \_\_\_\_\_  
 Appointments,  Financial,  Dental Treatment,  Insurance  Other (explain) \_\_\_\_\_

**DO NOT RELEASE INFORMATION TO ANYONE**

I understand that my express consent is required to release any health care information. With my signature below, I acknowledge and understand that this information will be kept in my medical record and the above parameters will remain in effect until revoked by me in writing. It is my responsibility to notify my healthcare provider(s) should I wish to change one or more contacts listed above.

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Signature of Patient or Authorized Representative: \_\_\_\_\_

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