

# Health History Form



American Dental Association  
www.ada.org

E-mail: \_\_\_\_\_ 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: Last First Middle                          | Home Phone: <i>Include area code</i><br>( ) | Business/Cell Phone: <i>Include area code</i><br>( )                                  |
| Address: _____<br><small>Mailing address</small> | City:                                       | State: Zip:   |
| Occupation:                                      | Height:                                     | Weight: Date of birth: Sex: M F   |
| SS# or Patient ID:                               | Emergency Contact:                          | Relationship: Home Phone: Cell Phone:<br>( ) ( )<br><small>Include area codes</small> |

If you are completing this form for another person, what is your relationship to that person?

Your Name \_\_\_\_\_ Relationship \_\_\_\_\_

**Do you have any of the following diseases or problems:** (Check DK if you Don't Know the answer to the question) **Yes No DK**

|   |                          |                          |                          |
|---|--------------------------|--------------------------|--------------------------|
| 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"/> |

**If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.**

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

|  | Yes                      | No                       | DK                       |  | Yes                      | No                       | DK                       |
|--|--------------------------|--------------------------|--------------------------|--|--------------------------|--------------------------|--------------------------|
| 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"/> |
| Does food or floss catch between your teeth? .....                         | <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"/> |
| Is your mouth dry? .....   | <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 had any periodontal (gum) treatments? .....                       | <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 ever had orthodontic (braces) 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"/> |
| Have you had any problems associated with previous dental treatment? ..... | <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"/> |
| Is your home water supply fluoridated? .....                               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Date of your last dental exam:                                   |                          |                          |                          |
| Do you drink bottled or filtered water? .....                              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | What was done at that time?                                      |                          |                          |                          |
| If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY               |                          |                          |                          | Date of last dental x-rays:                                      |                          |                          |                          |
| Are you currently experiencing dental pain or discomfort? .....            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |  |                          |                          |                          |

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.

|  | Yes                      | No                       | DK                       |   | Yes                      | No                       | DK                       |
|--|--------------------------|--------------------------|--------------------------|---|--------------------------|--------------------------|--------------------------|
| 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><br>( )                 |                          |                          |                          | 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 diet 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.

| <i>(Check DK if you Don't Know the answer to the question)</i>   | Yes                      | No                       | DK                       |   | Yes                      | No                       | DK                       |
|--|--------------------------|--------------------------|--------------------------|---|--------------------------|--------------------------|--------------------------|
| Do you wear contact lenses? .....  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Do you use controlled substances (drugs)? .....   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you taking, or have you taken, any diet drugs such as Pondimin (fenfluramine), Redux (dexphenfluramine) or phen-fen (fenfluramine-phentermine combination)? .....  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Do you use tobacco (smoking, snuff, chew, bidis)? .....                                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|  |                          |                          |                          | If so, how interested are you in stopping?<br>(Circle one) VERY / SOMEWHAT / NOT INTERESTED |                          |                          |                          |
| Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease? .....   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Do you drink alcoholic beverages? .....   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|  |                          |                          |                          | If yes, how much alcohol did you drink in the last 24 hours? _____                          |                          |                          |                          |
|  |                          |                          |                          | If yes, how much do you typically drink in a week? _____                                    |                          |                          |                          |
| Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) 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"/> | <b>WOMEN ONLY</b> Are you:  |                          |                          |                          |
| Date Treatment began: _____  |                          |                          |                          | Pregnant? .....   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|  |                          |                          |                          | Number of weeks: _____  |                          |                          |                          |
|  |                          |                          |                          | Taking birth control pills or hormonal replacement? .....                                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|  |                          |                          |                          | Nursing? .....  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**Joint Replacement.** Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? .....

Date: \_\_\_\_\_ If yes, have you had any complications? .....

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

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

|                                | Yes                      | No                       | DK                       |  | Yes                      | No                       | DK                       |  | Yes                      | No                       | DK                       |
|--------------------------------|--------------------------|--------------------------|--------------------------|--|--------------------------|--------------------------|--------------------------|--|--------------------------|--------------------------|--------------------------|
| Heart murmur .....             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Anemia .....                                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Chronic pain .....                         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Mitral valve prolapse .....    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Blood transfusion .....                        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes Type I or II .....                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Artificial heart valves .....  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | If yes, date: _____                            |                          |                          |                          | Eating disorder .....                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Rheumatic fever .....          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hemophilia .....                               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Malnutrition .....                         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Cardiovascular disease .....   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | AIDS or HIV infection .....                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Gastrointestinal disease .....             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Angina .....                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Arthritis .....                                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | G.E. Reflux/persistent heartburn .....     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Arteriosclerosis .....         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Autoimmune disease .....                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Ulcers .....                               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Congestive heart failure ..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Rheumatoid arthritis .....                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Thyroid problems .....                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Coronary artery disease .....  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Systemic lupus erythematosus .....             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Stroke .....                               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Damaged heart valves .....     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Asthma .....                                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma .....                             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart attack .....             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Bronchitis .....                               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis, jaundice or liver disease ..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Low blood pressure .....       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Emphysema .....                                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy .....                             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| High blood pressure .....      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sinus trouble .....                            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Fainting spells or seizures .....          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Congenital heart defects ..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis .....                             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Neurological disorders .....               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Pacemaker .....                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Cancer/Chemotherapy/ Radiation Treatment ..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | If yes, Specify: _____                     |                          |                          |                          |
| Rheumatic heart disease .....  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Chest pain upon exertion .....                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |  |                          |                          |                          |
| Abnormal bleeding .....        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |  |                          |                          |                          |  |                          |                          |                          |

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? .....

Name of physician or dentist making recommendation: \_\_\_\_\_ Phone: \_\_\_\_\_

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: \_\_\_\_\_

**FOR COMPLETION BY DENTIST**

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



## Appointment Cancellation Policy

At Rickoff Dentistry, we have implemented an appointment reminder and confirmation system that utilizes emails and cell phone text messages, as well as personal phone calls, to remind you and your family members of upcoming appointments with our office. It is our pleasure to provide these services to our patients at NO CHARGE as a means to better enhance your patient experience.

**If you are ever unable to keep a scheduled appointment with our dental office, we require at least a two (2) business day notice by calling our office to reschedule or cancel your appointment. If your notice is not received within the two (2) business day window, a small, short-notice fee of \$25.00 may be charged to your account.**

## Patient Financial Responsibility

As a condition of your treatment by this office, I understand that payment in full is due at the time services are rendered. I may pay with cash, personal check, credit or debit card, or CareCredit. I understand that all emergency dental services or any service performed after regular business hours must be paid at the time services are rendered.

A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all delinquent accounts, starting on the date the debt was incurred.

I consent and understand that any fee estimate or insurance estimate given to me as part of my treatment plan fees is only an estimate, and due to the nature of dental care and the unforeseen problems or changes that may arise during treatment, fees and/or treatment may also change as a result.

In the event that my account becomes delinquent, I understand that future treatment may be delayed until the balance has been paid. I also understand that if my account becomes delinquent, I shall be solely responsible for any and all collection fees, attorney fees, court costs, interest charges, and any other reasonable fee or charge as a result of my delinquent account.

If I choose Assignment of Benefits with regards to my insurance plan reimbursements, I authorize payment of dental benefits, otherwise payable to me, directly paid to Rickoff Dentistry. I also grant my permission to you or your assignee, to telephone me at home or work to discuss matters related to this form. I have read the above conditions of treatment and payment and agree to their content.

\_\_\_\_\_  
*Signature of Patient*

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Printed Name*



## Acknowledgement of Receipt of HIPAA Notice & Privacy Practices

I, \_\_\_\_\_, hereby acknowledge that I have received and reviewed a copy of Rickoff Dentistry's HIPAA Notice of Privacy Practices.

I understand that Rickoff Dentistry's HIPAA Notice of Privacy Practices may change periodically and that I am entitled to receive a copy of Rickoff Dentistry's revised HIPAA Notice of Privacy Practices upon request.

I understand that, if I have questions about Rickoff Dentistry's HIPAA Notice of Privacy Practices, I may contact the privacy official at Rickoff Dentistry.

I understand that it is my right to refuse to sign this Acknowledgement should I so choose, and that Rickoff Dentistry will not refuse treatment to me if I refuse to sign this Acknowledgement.

I further understand that I may contact the Secretary of the U.S. Department of Health and Human Services should I have concerns regarding Rickoff Dentistry's privacy policies and procedures.

\_\_\_\_\_  
*Signature of Patient* \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Signature of Responsible Party* \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Printed Name of Responsible Party* \_\_\_\_\_  
*Relationship*

\_\_\_\_\_  
*Signature of Staff Member* \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
*Date*