

Dr. Chris Houser, D.M.D., P.C. - Heritage Hunt Dental

Full Name _____ Nickname _____

Dental History

When was your last cleaning and exam? _____ x-rays? _____ dental visit? _____

How often do you brush? _____ floss? _____ other hygiene method(s)? _____

Do you **currently** have problems with any of the following (please check yes or no):

- | | | |
|---|--|---|
| <input type="checkbox"/> Y <input type="checkbox"/> N Bad breath | <input type="checkbox"/> Y <input type="checkbox"/> N Tooth, mouth or facial pain | <input type="checkbox"/> Y <input type="checkbox"/> N Clicking or popping jaw |
| <input type="checkbox"/> Y <input type="checkbox"/> N Loose teeth | <input type="checkbox"/> Y <input type="checkbox"/> N Food collecting between teeth | <input type="checkbox"/> Y <input type="checkbox"/> N Grinding or clenching teeth |
| <input type="checkbox"/> Y <input type="checkbox"/> N Dry mouth | <input type="checkbox"/> Y <input type="checkbox"/> N Teeth sensitive to cold or hot | <input type="checkbox"/> Y <input type="checkbox"/> N Burning sensation on tongue |
| <input type="checkbox"/> Y <input type="checkbox"/> N Difficulty chewing | <input type="checkbox"/> Y <input type="checkbox"/> N Teeth sensitive to biting | <input type="checkbox"/> Y <input type="checkbox"/> N Sores - mouth, head, or neck |
| <input type="checkbox"/> Y <input type="checkbox"/> N Bleeding gums | <input type="checkbox"/> Y <input type="checkbox"/> N Teeth sensitive to sweets | <input type="checkbox"/> Y <input type="checkbox"/> N Swelling- mouth, head, neck |
| <input type="checkbox"/> Y <input type="checkbox"/> N Mouth breathing | <input type="checkbox"/> Y <input type="checkbox"/> N Broken teeth or fillings | <input type="checkbox"/> Y <input type="checkbox"/> N Growth(s) - mouth, head, neck |
| <input type="checkbox"/> Y <input type="checkbox"/> N Fingernail biting habit | <input type="checkbox"/> Y <input type="checkbox"/> N Snoring or Sleep Apnea | <input type="checkbox"/> Y <input type="checkbox"/> N Dental treatment anxiety |

Do you have any of the following cosmetic concerns?

- Y N Discoloration of teeth - yellow/gray
- Y N Metallic fillings or crowns
- Y N Spacing, crowding, misalignment of teeth
- Y N Chipped or misshapen teeth Other

Any interest in the following cosmetic services?

- Y N Whitening/Bleaching - Zoom!®
- Y N Replace metallic restorations with white
- Y N Invisalign® - invisible alternative to braces
- Y N Porcelain veneers, bonding Other

Please use the space below to elaborate on any of the above or to describe other dental concerns not listed above:

Medical History

Height _____ Weight _____ Birthdate _____ Gender: M F

Physician's name _____ Phone # _____ Date of last examination _____

Have you been under the care of a physician for any condition, had an operation, or been hospitalized in the past 5 yrs?

Medications: Please list below and reason for use (if known). Include over-the-counter drugs and supplements.

Pharmacy Name _____ Location _____ Phone # _____

Do you use tobacco products? Y N alcoholic beverages? Y N recreational drugs? Y N

Specify frequency of use: _____

Allergies: Medications (specify) _____ | Latex Local anesthetics Metals

Seasonal/Environmental Other (specify) _____

Women only: Are you or could you be pregnant? Y N Due date: _____ Are you nursing? Y N

Please complete other side.

Please check yes or no whether you have had any of the following:

- | | |
|--|---|
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart Murmur | <input type="checkbox"/> Y <input type="checkbox"/> N Mitral Valve Prolapse |
| <input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic Fever | <input type="checkbox"/> Y <input type="checkbox"/> N Subacute Bacterial Endocarditis |
| <input type="checkbox"/> Y <input type="checkbox"/> N Artificial or Damaged Heart Valves | <input type="checkbox"/> Y <input type="checkbox"/> N Orthopedic Joint Replacement |
| <input type="checkbox"/> Y <input type="checkbox"/> N Angina | <input type="checkbox"/> Y <input type="checkbox"/> N Arteriosclerosis |
| <input type="checkbox"/> Y <input type="checkbox"/> N Congestive Heart Failure | <input type="checkbox"/> Y <input type="checkbox"/> N Coronary Artery Disease |
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart Attack | <input type="checkbox"/> Y <input type="checkbox"/> N Pacemaker |
| <input type="checkbox"/> Y <input type="checkbox"/> N High Blood Pressure | <input type="checkbox"/> Y <input type="checkbox"/> N Stroke |
| <input type="checkbox"/> Y <input type="checkbox"/> N Diabetes | <input type="checkbox"/> Y <input type="checkbox"/> N Blood Clotting Problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N AIDS/HIV | <input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis/Liver Disease |
| <input type="checkbox"/> Y <input type="checkbox"/> N Asthma | <input type="checkbox"/> Y <input type="checkbox"/> N Respiratory Problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N Anemia | <input type="checkbox"/> Y <input type="checkbox"/> N Kidney Disease |
| <input type="checkbox"/> Y <input type="checkbox"/> N Gastrointestinal Disease | <input type="checkbox"/> Y <input type="checkbox"/> N Thyroid Problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N Autoimmune Disease | <input type="checkbox"/> Y <input type="checkbox"/> N Immuno-suppression Condition |
| <input type="checkbox"/> Y <input type="checkbox"/> N Epilepsy or Seizure Disorder | <input type="checkbox"/> Y <input type="checkbox"/> N Cancer |
| <input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis | <input type="checkbox"/> Y <input type="checkbox"/> N Sexually Transmitted Disease |
| <input type="checkbox"/> Y <input type="checkbox"/> N Mental Health Disorder | <input type="checkbox"/> Y <input type="checkbox"/> N Eating Disorder |
| <input type="checkbox"/> Y <input type="checkbox"/> N Chemical Dependency | <input type="checkbox"/> Y <input type="checkbox"/> N Migraines |
| <input type="checkbox"/> Y <input type="checkbox"/> N Chronic Pain | <input type="checkbox"/> Y <input type="checkbox"/> N Back Problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N Osteoporosis | <input type="checkbox"/> Y <input type="checkbox"/> N Arthritis |
| <input type="checkbox"/> Y <input type="checkbox"/> N Glaucoma | <input type="checkbox"/> Y <input type="checkbox"/> N Sinus Problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N Snoring or Sleep Apnea | <input type="checkbox"/> Y <input type="checkbox"/> N Other _____ |

Please use the space below to elaborate on any of the above or to explain any other condition not listed above.

Patient's signature _____ Date _____ Dr.'s signature _____

Medical and Dental History Updates: Please review all above questions and note any changes below.

1. _____

Patient's signature _____ Date _____ Dr.'s signature _____

2. _____

Patient's signature _____ Date _____ Dr.'s signature _____

3. _____

Patient's signature _____ Date _____ Dr.'s signature _____

Dr.'s notes _____

Patient's Personal Information

Full Name _____ Nickname _____

Address: _____ City _____ State _____ Zip _____

Phone #'s: Home _____ Work _____ Cell/Other _____

Birthdate: _____ Gender: M F SS# _____ Email _____ Employer _____

Occupation _____ Student Status:

Not applicable Full time Part time School Name _____

Marital Status: Married Single Divorced Separated Widowed

Emergency Contact: Name _____ Relationship _____ Phone# _____

If completing this form for another person: Name _____ Relationship _____

Person Responsible for Account (if different than patient)

Full Name _____ DOB _____ SS# _____

Address _____ Email _____

Phone #'s: Home _____ Work _____ Cell/Other _____

Employer _____ Occupation _____

Employer's Address _____

Primary Insurance Subscriber and Carrier Information (if different than above):

Full Name _____ DOB _____ SS# _____

Address _____ Email _____

Phone #'s: Home _____ Work _____ Cell/Other _____

Employer _____ Occupation _____

Employer's Address _____ Phone# _____

Insurance Carrier _____ Group # _____ ID# _____

Insurance Address _____ Phone # _____

Secondary Insurance Subscriber and Carrier Information (if different than above):

Full Name _____ DOB _____ SS# _____

Address _____ Email _____

Phone #'s: Home _____ Work _____ Cell/Other _____

Employer _____ Occupation _____

Employer's Address _____ Phone# _____

Insurance Carrier _____ Group # _____ ID# _____

Insurance Address _____ Phone # _____

How did you hear about our office? Referral _____ Insurance _____

Advertisement – Please Specify: _____

Any other family members, friends or coworkers who are patients here? If so, please list below and specify relation.

Where are you originally from? _____ Are you a veteran? _____

Hobbies/Interests: _____

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Authorizations and Agreements

Appointments

Every appointment you schedule is reserved exclusively for you. There is a fee for failing to keep appointments. We understand that occasionally due to circumstances beyond your control it may be necessary to reschedule an appointment. We ask that you kindly give at least 24 hours notice for any appointment changes.

Initial _____

Patient Privacy

I have received a copy of this office's "Notice of Privacy Practices" and consent to your use and disclosure of my protected health information to carry out treatment, payment activities (eg. in connection with insurance claims), healthcare operations, or when required by law. I understand my rights concerning my health information.

Initial _____

Financial Matters

Dr. Houser only places white/tooth-colored fillings (composite resin). Your insurance company may downgrade your benefit to the silver-mercury filling (amalgam) fee and you will be responsible for the difference in cost. Please initial here to acknowledge this. →

Initial _____

Balances over 30 days past due will be subject to an interest charge of 1.5% per month each month that the payment is outstanding. The returned check fee is \$75. In the event that this account is turned over to an attorney for collection, you agree to pay all collection costs including interest charges, attorney's fees and court costs. We do realize that temporary financial problems may affect timely payment in some cases. We encourage open communication with our office in order to arrange mutually agreeable payment terms.

It is important for you to keep us informed of any changes in your employment and/or insurance. We will (in most cases) submit insurance claims for you. Any assistance in this matter does not imply any actual responsibility on our part. This is a courtesy we extend to you and, if necessary, will retract; thereby, making you responsible for all claims submissions. In this case, all fees (not just co-payments) would be due at the time services are rendered.

I authorize direct payment of dental benefits to Heritage Hunt Dental. I acknowledge that my signature on this document authorizes my doctor to submit claims for benefits for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or my dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claims.

Payments for services rendered are due at time of service. I agree to make payment for all charges for dental services not paid for by my dental benefit plan (if applicable) at the time of service. If my insurance does not make payment to Heritage Hunt Dental within 30 days for the balance owed, I will take responsibility for payment.

Patient/Guardian Signature _____ Date _____

Insurance Subscriber's Signature _____ Date _____