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):

□Y □N	Bad breath	□Y □N	Tooth, mouth or facial pain	□Y □N	Clicking or popping jaw
□Y □N	Loose teeth	□Y □N	Food collecting between teeth	□Y □N	Grinding or clenching teeth
□Y □N	Dry mouth	□Y □N	Teeth sensitive to cold or hot	□Y □N	Burning sensation on tongue
□Y □N	Difficulty chewing	□Y □N	Teeth sensitive to biting	□Y □N	Sores - mouth, head, or neck
□Y □N	Bleeding gums	□Y □N	Teeth sensitive to sweets	□Y □N	Swelling- mouth, head, neck
□Y □N	Mouth breathing	□Y □N	Broken teeth or fillings	□Y □N	Growth(s) - mouth, head, neck
□Y □N	Fingernail biting habit	□Y □N	Snoring or Sleep Apnea	□Y □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:

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