

# Huffman & Kreger Family Dentistry

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

## GETTING TO KNOW YOU AS OUR PATIENT

Patient Name		Social Security Number		Home Phone (      )	
Home Address		City, State, Zip		Cell Phone	
Email Address				Work Phone	
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Separated		<input type="checkbox"/> <b>MALE</b> <input type="checkbox"/> <b>FEMALE</b>		Birthdate	Drivers License and State

Primary Insurance Company \_\_\_\_\_ Group \_\_\_\_\_ Subscriber \_\_\_\_\_

Secondary Insurance Company \_\_\_\_\_ Group \_\_\_\_\_ Subscriber \_\_\_\_\_

<b>Responsible Party</b>		
Name	Social Security Number	Home Phone (       )
Home Address	City, State, Zip	Birthdate /         /
Martial Status <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Separated	Relationship to Patient	Drivers License and State
Responsible Person's Employer	Occupation	Work Phone (       )
Business Address	City	State                      Zip

Spouse's Name	Social Security Number	Birthdate / /
Spouse's Employer	Spouse's Occupation	Spouse's Work Phone ( )
Spouse's Business Address	City	State Zip

## CONSENT

\*I will answer all health questions to the best of my knowledge. \_\_\_\_\_  
(Initial)

After explanation by the doctor, I hereby authorize the performance of dental services upon the above named patients and whatever procedures that the judgement of the doctor may dictate in order to carry out these procedures. I also authorize and request the administration of any anesthetics and x-rays as may be deemed necessary and advisable by the doctor.

*Signature	Date
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Date \_\_\_\_\_

Relationship to Patient

## Terms and Conditions

This office depends upon reimbursement from the patient for the costs incurred in their care. The financial responsibility of each patient must be determined before treatment.

As a condition of treatment by this office, I understand financial arrangements must be made in advance. All emergency dental services, or any dental service performed without prior financial arrangement, must be paid for at the time services are performed.

I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company.

**Assignment of Insurance:** I hereby authorize release of any information needed and also authorize my insurance company to pay directly to this office benefits accruing to me under my policy.

I understand that the fee estimate listed for this dental care can only be extended for a period of 90 days from the date of the patient's examination. I also understand that in order to collect my debt, my credit history may be checked through the use of my Social Security Number or any other information I have given you. I agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorney's fees.

I grant my permission to you, or your assigns, to telephone me at home or at my work to discuss matters related to this form. I have read the above the conditions and agree to their content.

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

OUR OFFICE IS HIPAA COMPLIANT AND IS COMMITTED TO MEETING OR EXCEEDING THE STANDARDS OF INFECTION CONTROL MANDATED BY OSHA, THE CDC, AND THE ADA.      Sign \_\_\_\_\_ Date \_\_\_\_\_

# Huffman & Kreger Family Dentistry

Why have you come to see us today? (e.g.: pain, checkup, etc.) \_\_\_\_\_

Previous Dentist \_\_\_\_\_ Last Visit \_\_\_\_\_ Date of last cleaning \_\_\_\_\_

Reasons for changing dentists: \_\_\_\_\_

What problems have you had with past dental treatment? \_\_\_\_\_

Are you nervous about seeing a dentist? ☐ Yes! ☐ No If yes please, tell us why: \_\_\_\_\_

How often do you brush? \_\_\_\_\_ Do you floss? ☐ Yes ☐ No How often? \_\_\_\_\_

(Please circle each)

Y N I clench or grind my teeth during the day or while sleeping.	Y N I avoid brushing part of my mouth due to pain.	Y N I have had a facial or jaw injury.
Y N My gums bleed while brushing or flossing.	Y N My gums feel tender or swollen.	Y N I want my teeth straighter.
Y N I would like to improve my smile.	Y N I have problems eating.	Y N I want my teeth whiter.
Y N I prefer tooth-colored fillings.	Y N I have had orthodontics.	

What are your dental priorities? \_\_\_\_\_

(e.g.: appearance, dental health, financial considerations, etc.)

I consider my health to be (check one): ☐ Excellent ☐ Good ☐ Fair ☐ Poor

## PATIENT'S MEDICAL HISTORY

**Do you have or have you had any of the follow? Please circle Y for yes or N for no.**

- |   |  |   |
|---|--|---|
| 1. Y N Heart Disease                      | 25. Y N Liver Disease                          | 39. Y N HIV                                       |
| 2. Y N Heart Murmur/Mitral Valve Prolapse | 26. Y N Jaundice                               | 40. Y N AIDS                                      |
| 3. Y N Stroke                             | 27. Y N Hepatitis Type _____                   | 41. Y N Immune Suppressed Disorder                |
| 4. Y N Congenital Heart Lesions           | 28. Y N Diabetes                               | 42. Y N Hearing Loss                              |
| 5. Y N Rheumatic Fever                    | 29. Y N Excessive Urination and/or Thirst      | 43. Y N Fainting Spells                           |
| 6. Y N Pacemaker                          | 30. Y N Infectious Mononucleosis ("Mono")      | 44. Y N Glaucoma                                  |
| 7. Y N Stent                              | 31. Y N Herpes                                 | 45. Y N History of Emotional or Nervous Disorders |
| 8. Y N Abnormal Blood Pressure            | 32. Y N Arthritis                              |   |
| 9. Y N Anemia                             | 33. Y N Sexually Transmitted/Venereal Diseases |   |
| 10. Y N Prolonged Bleeding Disorder       | 34. Y N Kidney Disease                         |   |
| 11. Y N Tuberculosis or Lung Disease      | 35. Y N Tumor or Malignancy                    |   |
| 12. Y N Asthma                            | 36. Y N Cancer/Chemotherapy                    |   |
| 13. Y N Hay Fever                         | 37. Y N Radiation/Therapy                      |   |
| 14. Y N Sinus Trouble                     | 38. Y N History of Drug Addiction              |   |
| 15. Y N Epilepsy/Seizures                 |  |   |
| 16. Y N Ulcers                            |  |   |

17. Y N Implants/Artificial Joints: Hip-Knee \_\_\_\_\_ Other \_\_\_\_\_

18. Y N I smoke or use chewing tobacco If yes, how much per day? \_\_\_\_\_ How many years? \_\_\_\_\_

19. Y N I have consumed alcohol within the last 24 hours.

20. Y N I usually take antibiotic prior to dental treatment

21. Y N Have you ever taken Fen-Phen or Redux?

22. Y N Do you take or have you ever taken Bisphosphonates (Fosamax, Boniva, Actonel, Aredia, Zometa, etc.) for Osteoporosis or any other condition?

23. Y N I have had major surgery Year \_\_\_\_\_ Type of operation \_\_\_\_\_ Year \_\_\_\_\_ Type of operation \_\_\_\_\_

24. Y N Do you have any other medical problem or medical history NOT listed on this form? \_\_\_\_\_

Doctor Notes Only:

**Are you allergic to any of the following?**

**Please circle y for Yes or N for no**

48. Y N Aspirin  
49. Y N Ibuprofen  
50. Y N Sulfa Drugs/Sulfites/Sulfides  
51. Y N Penicillin  
52. Y N Codeine  
53. Y N Latex, Metals, Plastics  
54. Y N Local Anesthetics (i.e., Novocain, Lidocaine)  
55. Y N Other Medications Which ones? \_\_\_\_\_

**Please list all medications you are currently taking:**

Medicine \_\_\_\_\_ Condition \_\_\_\_\_

Medicine \_\_\_\_\_ Condition \_\_\_\_\_

Medicine \_\_\_\_\_ Condition \_\_\_\_\_

Medicine \_\_\_\_\_ Condition \_\_\_\_\_

Physician's Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ Fax \_\_\_\_\_

**In the event of an emergency please contact:**

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_