

Health History Form

ADA American Dental Association®

America's leading advocate for oral health

Email: 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> ()	Business/Cell Phone: <i>Include area code</i> ()
Address: <i>Mailing address</i>	City:	State: Zip:
Occupation:	Height:	Weight: Date of Birth: Sex: M F
SS# or Patient ID:	Emergency Contact:	Relationship: Home Phone: <i>Include area code</i> () Cell Phone: <i>Include area code</i> ()

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 *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"/>
Is your mouth dry?	<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"/>
Have you had any periodontal (gum) treatments?	<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 ever had orthodontic (braces) treatment?	<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 had any problems associated with previous dental 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"/>
Is your home water supply fluoridated?	<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"/>
Do you drink bottled or filtered water?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Date of your last dental exam:			
If yes, how often? (Check one): DAILY <input type="checkbox"/> / WEEKLY <input type="checkbox"/> / OCCASIONALLY <input type="checkbox"/>				What was done at that time?			
Are you currently experiencing dental pain or discomfort?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Date of last dental x-rays:			
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: <input type="text"/>				If yes, what was the illness or problem?			
Phone: <i>Include area code</i> ()				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"/>
Address/City/State/Zip:				If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements:			
Are you in good health?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____			
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.

<p><small>(Check DK if you Don't Know the answer to the question)</small></p> <p>Do you wear contact lenses? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Date: _____ If yes, have you had any complications? _____</p> <p>Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax*, Actonel*, Atelvia, Boniva*, Reclast, Prolia) for osteoporosis or Paget's disease? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia*, Zometa*, XGEVA) 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"/></p> <p>Date Treatment began: _____</p>	<p>Do you use controlled substances (drugs)? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Do you use tobacco (smoking, snuff, chew, bidis)? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>If so, how interested are you in stopping? Circle one: VERY / SOMEWHAT / NOT INTERESTED</p> <p>Do you drink alcoholic beverages? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>If yes, how much alcohol did you drink in the last 24 hours? _____</p> <p>If yes, how much do you typically drink in a week? _____</p> <p>WOMEN ONLY Are you:</p> <p>Pregnant? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Number of weeks: _____</p> <p>Taking birth control pills or hormonal replacement? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Nursing? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
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<p>Allergies. Are you allergic to or have you had a reaction to: To all yes responses, specify type of reaction.</p> <p>Local anesthetics <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Aspirin <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Penicillin or other antibiotics <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Barbiturates, sedatives, or sleeping pills <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Sulfa drugs <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Codeine or other narcotics <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>	<p>Yes No DK</p> <p>Metals <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Latex (rubber) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Iodine <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Hay fever/seasonal <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Animals <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Food <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Other <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
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Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

<p>Yes No DK</p> <p>Artificial (prosthetic) heart valve <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Previous infective endocarditis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Damaged valves in transplanted heart <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Congenital heart disease (CHD)</p> <p style="padding-left: 20px;">Unrepaired, cyanotic CHD <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p style="padding-left: 20px;">Repaired (completely) in last 6 months <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p style="padding-left: 20px;">Repaired CHD with residual defects <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>	<p>Yes No DK</p> <p>Autoimmune disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Rheumatoid arthritis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Systemic lupus erythematosus <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Asthma <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Bronchitis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Emphysema <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Sinus trouble <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Tuberculosis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Cancer/Chemotherapy/ Radiation Treatment <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Chest pain upon exertion <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Chronic pain <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Diabetes Type I or II <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Eating disorder <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Malnutrition <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Gastrointestinal disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>G.E. Reflux/persistent heartburn <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Ulcers <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Thyroid problems <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Stroke <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>	<p>Yes No DK</p> <p>Glaucoma <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Hepatitis, jaundice or liver disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Epilepsy <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Fainting spells or seizures <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Neurological disorders <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p style="padding-left: 20px;">If yes, specify: _____</p> <p>Sleep disorder <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Do you snore? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Mental health disorders <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p style="padding-left: 20px;">Specify: _____</p> <p>Recurrent Infections <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p style="padding-left: 20px;">Type of infection: _____</p> <p>Kidney problems <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Night sweats <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Osteoporosis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Persistent swollen glands in neck <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Severe headaches/ migraines <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Severe or rapid weight loss <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Sexually transmitted disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Excessive urination <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
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Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

<p>Yes No DK</p> <p>Cardiovascular disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Angina <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Arteriosclerosis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Congestive heart failure <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Damaged heart valves <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Heart attack <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Heart murmur <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Low blood pressure <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>High blood pressure <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Other congenital heart defects <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>	<p>Yes No DK</p> <p>Mitral valve prolapse <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Pacemaker <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Rheumatic fever <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Rheumatic heart disease <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Abnormal bleeding <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Anemia <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Blood transfusion <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p style="padding-left: 20px;">If yes, date: _____</p> <p>Hemophilia <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>AIDS or HIV infection <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Arthritis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>
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Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?

Name of physician or dentist making recommendation: _____ Phone: Include area code () _____

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: _____

Signature of Dentist: _____ Date: _____

FOR COMPLETION BY DENTIST

Comments: _____



Patient Name _____ Date _____

General Consent for Treatment: HIPPA & Privacy ACT:

I hereby consent to and authorize Lynbrook Smiles; The Health Insurance Portability and Accountability Act requires that this office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future. This policy contains information that HIPAA requires us to disclose regarding our privacy practices. We are also required to obtain your written consent and acknowledgement prior to disclosing any of your information except for our disclosures in connection with: defense to a claim challenging our professional competence; a review of entity's functions; a claim for payment of fees; a third party payer's examination of our records; court order as a part of a criminal investigation; an identification of a dead body; a licensure investigation; or a child abuse/neglect investigation. It may be necessary for us to make disclosures of your information in connection with your treatment. For example, we may make a referral to or consult with another dentist or health care professional, provide material to a laboratory, or otherwise make disclosures of your information in connection with providing or coordinating your treatment. Website: <https://omh.ny.gov/omhweb/hipaa/>

Signature: _____

Consent: Release of Information to Insurance Companies and Third-Party Payors

I hereby authorize and direct Lynbrook Smiles, having treated me, to release to government agencies, Social Security Administration and the Centers for Medicare and Medicaid Services or its intermediaries or carriers, insurance carriers, and/or others who are financially liable for my dental care, all information needed to substantiate payment for such care, and to permit representatives thereof to examine and make copies of all records relating to such treatment to the extent necessary to process claims.

Signature: _____

Assignment of Benefit to Lynbrook Smiles

I hereby assign, transfer, and set over to Lynbrook Smiles, sufficient monies, and benefits to which I may be entitled from governmental agencies, insurance carriers, and/or others who are financially liable for my dental care to cover the cost of the care rendered to me or my dependent.

Signature: _____



Financial Responsibility/ Guarantee of Payment

For, and in consideration of, services rendered by Lynbrook Smiles, I hereby guarantee payment of any bills for such services that or not covered or allowed by the governmental agencies or insurance carriers financially liable for such services.

Signature: _____

No-Show/Cancellation Policy:

Our office will charge a fee of \$100.00 to your account for all "no-shows" or cancellations in which the patient does not give our office a 48-hour notice. The office requests that if you are unable to make your scheduled appointment, you call to reschedule your appointment. If it is after or before regular business hours, please leave a message and we will return your call.

Signature: _____

Credit Card Authorization Form:

In the event that outstanding balances are not settled by insurance within 60 days, the office reserves the right to charge the provided card on file for the remaining amount.

Card type:

- Master card, Visa, Discover, and Amex

Cardholder Name(as shown on card) _____

Card Number: _____

Expiration Date: ____/____ CVV: _____

I, _____, authorize Lynbrook Smiles to charge my credit card for agreed upon balance payments. I understand that the information above will be saved on file for future transactions on my account.

Signature _____

Dental Insurance Information

Primary Insurance Company's Name: _____ Patient: YES/NO

Name Of Insured: _____ DOB: _____

Id# _____ Group# _____

Phone: _____ Email: _____

Street Address: _____ City: _____ State: _____

Secondary Insurance Company's Name: _____ Patient: YES/NO

Name Of Insured: _____ DOB: _____

Id# _____ Group# _____

Phone: _____ Email: _____

Street Address: _____ City: _____ State: _____

Email & Text Messaging Consent Form

We are happy to provide patients with the option to participate in our online patient communications system. Some of the features include:

1. Request Appointments Via Email
2. Confirm Appointments Via Email/Text
3. Receive Text Messages Appointments Reminders.

I consent to receiving information Via email or text:

Email Address: _____ Phone# _____

Please sign below to indicate that you agree to allow us to use this information in providing your services. You may choose to discontinue your participation in our online communication system at any time.

Signature: _____ DATE: _____



Financial Agreement

Dental treatment is an excellent investment in an individual's medical and psychological well-being. Financial considerations should not be an obstacle to obtaining health services. If your insurance company rejects a claim and refuses to pay for a service, it is not a reflection of how important the service is.

Please note our agreement is with you, NOT your insurance company. If your insurance company refuses to pay or pays less than estimated, you must remember that dental insurance is designed to offset the costs of your dental treatment. You are responsible for the costs of your dental treatment and any insurance reimbursement conflicts. Our office staff will help you to the best of our ability to obtain your maximum benefits. We strongly advise you as our patient, to familiarize yourself with your dental coverage and your benefits.

We will wait a MAXIMUM of 45 days for your insurance company to respond with a payment, denial, or no response after that complete payment is the patient's responsibility. Any remaining balance will be subject to a finance charge of 1.5% per month with a minimum finance charge of \$.50 per month. Balances older than 60 days (after insurance company payment, denial, no response or two billings) will be forwarded to collections with a collection agency.

We are providing the following payment options, being sensitive to the fact that different people have different needs in fulfilling their financial obligations:

WE accept checks, cash, Visa, MasterCard, and Discover.

We offer a 5% prepay special discount for all treatment paid for at the time of scheduling, for qualifying cases if paying by cash only.

We offer interest free, extended payment plans through Care Credit for certain qualifying cases. In-office contract with an extended payment plan (3 installments).

Per our office policy of participating with insurance as part of full payment:

We require a copy of your credit/debit card to be kept on file with our office.

We collect a deposit based on estimation of coverage from your insurance company. We will contact them before treatment to find out coverage.

If there is an overpayment by the insurance carrier, we will reimburse you as soon as possible.

If there is a balance due after we receive your insurance, you authorize us to charge your credit card that is on file for the remaining balance.

If the insurance company mails payment directly to you, the patient, or the insurance company has not paid within 45 days of submission, you authorize us to charge your credit card that is on file for the balance.

Please note: Our office has a 48-hour cancellation policy. Your appointment time is reserved for you as out patient to provide you with outstanding care for your dental needs. We strive to provide you with a two-day courtesy reminder via text or phone call. However, it is ultimately your responsibility to remember your dental appointments. Please take note that there is a \$75 late fee for appointments cancelled with less than 48-hour notice.

To avoid increased fees to all patients, any account balance over 30 days will be assessed a fee of 18% of the balance due. All accounts over 90 days will be notified in writing of their account being transferred to a collection agency.

Patient Name: _____

Patient's Signature: _____

Date: _____

EMPLOYMENT INFORMATION:

Place of Employment: _____

Address: _____

Phone #: _____