The Heights Dental Clinic

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Welcome! We are committed to excellent patient care and appreciate you taking the time to complete this confidential questionnaire. We look forward to getting to know you.

Whom may we thank for referring you? _____

ABOUT YOU

Name: _____ I prefer to be called_____ [ ] Male [ ] Female
[ ] Single [ ] Married [ ] Child [ ] Other Birth date: ___/___/___ Age: _____ S.S. #: _____

Home Address: _____
City_____State_____ Zip_____

Home Phone: (____) _____ Work: (____) _____ ext. ___ Cell: (___) _____
E-mail Address: _____

Employer: _____
Occupation: _____
Employer's Address: _____
City_____ State_____ Zip_____

PERSON RESPONSIBLE FOR ACCOUNT

[ ] Same as above
Name: _____ Birth date:___/___/___ Relation: _____
Billing Address: _____ City_____ State_____ Zip_____
Home Phone: (____) _____ Work: (____) _____ ext. ___ Cell: (___) _____
S.S. #: _____
Employer: _____

EMERGENCY CONTACT INFORMATION

Name: _____
Employer: _____ Phone: (____) _____

DENTAL INSURANCE INFORMATION

Primary Insurance

Insurance Co. Name: _____Phone: (____) _____ Group/Policy #: _____
Insured's Name: _____Insured's Birth date: ___/___/___
Insured's Social Security #: _____ Insured's Employer: _____

Secondary Insurance

Insurance Co. Name: _____ Phone: (____) _____ Group/Policy #: _____
Insured's Name: _____ Insured's Birth date: ___/___/___
Insured's Social Security #: _____ Insured's Employer: _____

Heights Dental Clinic

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____

Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you,
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

Consent for Treatment

Christopher L. Houk DDS PA

APPOINTMENT POLICY

We value your time and made every effort to see you at the appointed time and to minimize your time spent in our office. In return, when you make an appointment with us please be on time since we have reserved our time just for you. Patients that fail to give a 24-hour notice of appointment cancellation will be billed $75 for that appointment time.

FINANCIAL POLICY

We are happy to file your insurance for you, but we ask that you pay your estimated percentage at the time of your appointment. Patients are personally responsible for the payment of all dental services to be paid the day services are rendered. Patients that do not request a quotation of fees for services waive their right to later claim the fee exceeded the value of the services rendered. Fees are always discussed with patients prior to treatment. If delinquent, patients are responsible for all collection and attorney fees

AUTHORIZATION AND CONSENT

General Consent to Treatment

I consent to a dental examination and the recommended treatment to be performed as mutually agreed upon by me. I understand that additional diagnostic procedures and dental treatments may be recommended and will be discussed with me prior to being done. Also, I acknowledge that there are no guarantees, expressed or implied, as to the results of any procedures or dental treatments performed.

Release of Information

I authorize The Heights Dental Clinic to release any information regarding my dental/medical history, diagnosis or treatment to third party payers and/or other health professionals.

Assignment of Insurance Benefits

I authorize and request my insurance company to pay my benefits directly to The Heights Dental Clinic.

Photography Release

I authorize Dr. Houk and staff members to take photographs of me to help me better understand my current dental condition and possible treatment options.

Local Anesthesia Informed Consent

Local anesthesia may be used during dental treatment. This consent form is designed to make you aware of the risks involved with local anesthesia. The risks include, but are not limited to:
Physiological effects such as dizziness, nausea, vomiting, accelerated heart rate, slow heart rate or various types of allergic reactions. Restricted mouth opening during recovery related to muscle soreness at the site of the injection. In rare instances this may require physical therapy. Prolonged numbness. This is especially concerning for children who may bite, chew or suck anesthetized areas of the mouth resulting in swollen lips, tongues, and cheeks. This type of trauma may also cause sores and ulcers. Injury to nerves that can result in pain, numbness, tingling or other sensory disturbances to the chin, lip, cheek, gums, or tongue. This may persist for several weeks, months or, in rare instances, be permanent. Local anesthesia is administered with a very fine, small needle. In very rare circumstances these needles may break off and be lodged in soft tissue.

NITROUS OXIDE AND OXYGEN INFORMED CONSENT

Nitrous oxide/oxygen may be used during dental treatment. Nitrous oxide is perhaps the safest sedative used in dentistry. It is non-addictive. It is mild, easily absorbed and quickly eliminated from the body. The patient remains fully conscious and maintains all natural reflexes when breathing nitrous oxide/oxygen. This consent form is designed to make you aware of the risks involved with nitrous oxide/oxygen. The risks include, but are not limited to:
Occasional nausea or vomiting. Certain respiratory conditions that make breathing through the nose difficult may limit the effectiveness of nitrous oxide/oxygen. Certain medications can react negatively with nitrous oxide. Please inform the dentist of ALL medications being taken. If the patient is pregnant please notify the staff and do not consent to the use of nitrous oxide.

I have read this entire consent for treatment and I understand, will comply with, and give informed consent to office **Appointment Policy**, **Financial Policy**, **General Consent to Treatment**, **Local Anesthesia and Nitrous Oxide Consent, Release of Information**.

X _____ Date _____

Signature of patient, parent or guardian

NOTICE OF PRIVACY FOR PROTECTED HUMAN INFORMATION

I hereby acknowledge that I have received a copy of this practice's Notice of Privacy Practices.
I understand that I may ask any questions I may have regarding this notice.

Signature _____ Date _____