Haight Street Dental

HEALTH HISTORY

DENTAL HISTORY

reason for today's visit _____

former dentist _____ city_____ phone_____

date of last dental visit _____ date of last x-rays _____

how often you brush? _____ how often do you floss?_____

check(✓) if you have or have had problems with any of the following:

- ☐ periodontal treatment
- ☐ grinding teeth
- ☐ mouth odors or bad tasted
- ☐ oral surgery
- ☐ loose teeth or broken fillings
- ☐ bleeding gums
- ☐ sensitivity to hot or cold
- ☐ sensitivity to sweets
- ☐ orthodontic treatment
- ☐ food collection between teeth
- ☐ clicking or popping jaw
- ☐ cold sore or other oral lesion
- ☐ sensitivity when biting

Is there anything you would like to change about your smile? _____

MEDICAL HISTORY

are you currently under a physician's care? _____

physician name/medical group _____ phone _____

have you had any serious illness or operations? _____ if so, please explain_____

woman: are you pregnant _____ if so, how many months? _____ nursing? _____ taking birth control pills? _____

check(✓) if you have or have had problems with any of the following:

- ☐ anemia
- ☐ arthritis/rheumatism
- ☐ artificial heart valves
- ☐ artificial joints diabetes
- ☐ epilepsy/seizures
- ☐ fainting/dizziness
- ☐ mitral valve prolapse
- ☐ pacemaker/heart surgery
- ☐ psychiatric care
- ☐ tuberculosis
- ☐ ulcer
- ☐ venereal disease
- ☐ cortisone treatment
- ☐ cough, persistent
- ☐ cough up blood
- ☐ jaw pain
- ☐ kidney disease
- ☐ liver disease
- ☐ thyroid disease
- ☐ tobacco habit
- ☐ tonsillitis
- ☐ chemical dependency
- ☐ circulatory problems
- ☐ swelling of feet or ankles
- ☐ hepatitis
- ☐ high blood pressure
- ☐ HIV+AIDS
- ☐ skin rash
- ☐ stroke
- ☐ blood disease
- ☐ blood transfusion
- ☐ cancer/tumors
- ☐ heart problems
- ☐ chemotherapy
- ☐ herpes
- ☐ hemophilia/abnormal bleeding
- ☐ rheumatic/scarlet fever
- ☐ shortness of breath
- ☐ sinus problems
- ☐ asthma
- ☐ back problems
- ☐ glaucoma
- ☐ headaches
- ☐ heart murmur
- ☐ radiation treatment
- ☐ rapid weight gain or loss
- ☐ respiratory disease

Do you have or have you had any disease, condition or problem not listed above? ____

If so, please explain _____

List medications you are currently taking: _____

List allergies to any medication or substance: _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered every question on this form completely and accurately, to the best of my knowledge. I will inform my dentist of any changes in my health and/or medication.

Patient Signature_____ Date _____

Haight Street Dental REGISTRATION

PATIENT INFORMATION

first name _____ last name _____ nickname _____
gender _____ marital status _____ birthdate _____ ss# _____
address _____
city _____ state_____ zip _____
email _____
☐ home phone _____ ☐ work _____ ☐ cell _____ Please check your preferred number
whom may we thank for referring you to our office? _____
notify in case of emergency _____ phone _____

INSURANCE

insured person's name _____
relationship to patient _____ birthday _____ id# _____
address (if different from patient's) _____
city_____ state_____ zip _____
insured person's employer_____
insurance company _____ group # _____

AUTHORIZATION

I authorize and give consent to the performance of dental services for myself (or dependent). I give consent to any necessary or advisable dental procedures, medications, or anesthetic to be administered by the attending dentist or by supervised staff for diagnostic purposes or dental treatment. I understand that using anesthetic agents embodies certain risks.

patient signature _____ date _____

OUR POLICIES

Payment is due at the time services are rendered unless other arrangements have been made. Returned checks and outstanding balances over 60 days are subject to collections fees and an interest rate of 1.5% per month. If required, also understand a check of credit history may be made.

Appointments cancelled or broken with less than 48 hours of notice may be subject to a $50 cancellation fee. If multiple appointments are missed or cancelled a 50% (non-refundable) deposit may be required before scheduling future appointments.

I may receive a treatment plan which estimates my portion of payment. If the staff estimates and collects co-payments and my insurance underpays or denies a benefit, **I am responsible for remaining balance**.
Not all services are covered in insurance contracts. Insurance companies arbitrarily select certain procedures they do not cover, based upon the premium arranged by my employer.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY AND DENTAL MATERIALS FACT SHEET

I have seen the office notice of privacy practice and dental material's sheet and may receive a copy at my request.

Patient signature _____ date _____