HEALTH HISTORY FORM

Patient Information

Patients Name Last_____ M I:_____First_____ **Sex:** M F **DOB:**_____**Age:**____

Address_____City_____State_____Zip_____

Marital Status:_____Reason for this visit today_____ Todays date:_____

If patient is a minor, please give Parent/Guardian's name:_____ How did you hear about our office_____

Home Phone (_____)_____Work Phone (_____)_____Cell Phone (_____)_____

Primary Dental Insurance Information

Insured's Name_____
Insurance Co._____
Insurance Co. Address_____
Insured's Employer_____
Insured's DOB:_____**Subscriber I.D #**_____
Group #_____**Local #**_____
Insurance Phone #:_____

Secondary Dental Insurance Information

Insured's Name_____
Insurance Co._____
Insurance Co. Address_____
Insured's Employer_____
Insured's DOB:_____**Subscriber I.D #**_____
Group #_____**Local #**_____
Insurance Phone #:_____

Dental History

	yes	no
How long since your last **dental visit**? _____		
Last complete **dental exam**? _____		
Last time since you've had dental **x-rays** taken? _____		
Are you having any **problems** now?		
What? _____		
Is your present dental health **poor**?	☐	☐
Would you like to know more about **permanent replacements**?	☐	☐
Are you **apprehensive** about dental treatment?	☐	☐
Have you had any **periodontal** (gum) treatment?	☐	☐
Do your gums **bleed**, or feel tender or **irritated**?	☐	☐
Are your teeth **sensitive** to hot, cold, sweets, pressure? *circle all that apply*		
Are you **unhappy** with the **appearance** of your teeth?	☐	☐
Are you aware of any **grinding** or **clenching** your teeth?	☐	☐
Do you have **headaches**, **earaches**, or **neck pains**?	☐	☐
Have you worn **braces** on your teeth? (**Orthodontics**)	☐	☐
Do you have **discolored** teeth that bother you?	☐	☐
Would you like your smile to **look better or different**?	☐	☐
Do you **regularly** use **dental floss**?	☐	☐

Name of or your previous dentist:

_____

City:_____

State:_____Phone #: (_____)_____

How do you feel about your teeth?

Medical History

	yes	no
Do you have any **current health problems**?	☐	☐
Are you under a **physician's care** now?	☐	☐
If yes, what?		
_____		
What medications are you currently taking?		
_____		
_____		
_____		
_____		
_____		
_____		
_____		
_____		
Does your medical doctor require you to take an **antibiotic/pre-med** for dental appointments?	☐	☐
If yes, for what? _____		
Do you **smoke**? Use **chewing tobacco**? *Circle all that apply*	☐	☐
Are you **pregnant**?	☐	☐

Are you **Allergic** to or have you ever reacted adversely to any of the following medications? *Circle all that apply*

Aspirin	**Amoxicillin**	**Local Anesthetic**	**Penicillin**
Latex	**Codeine**	**Sulfa**	**Erythromycin**

Other: _____

_____

Is there any other medical or dental information that we should be aware of?

If yes, what? _____ Family Physician_____ Phone #_____

Circle any of the following which you have had, or presently have

Acid Reflux	Asthma	Emphysema	High Cholesterol	Sleep Apnea
AIDS/A.R.C/HIV positive	Autism	Epilepsy / Seizures	Kidney Trouble	Stents/valve replacement
Alcoholism	Blood Transfusion	Fever Blisters	Liver Disease	Stroke
Allergies or Hives	Chemotherapy -cancer, etc	Heart Disease / Attack	Mitral Valve Prolapse	Thyroid Disease
Anemia	Congenital Heart Lesions	Heart Pacemaker	Osteoporosis	Tuberculosis (TB)
Angina Pectoris	Cosmetic Surgery	Hemophilia -bleeding issue	Pain in Jaw Joints	Ulcers
Arthritis	C.O.P.D	Hepatitis A (Infectious)	Psychiatric Treatment	Venereal Disease (syphilis..)
Artificial Heart Valve	Diabetes	Hepatitis B-serum or Hep C	Radiation Treatment	Vertigo
Artificial Joints (Hip, knee)	Drug Addiction	High Blood Pressure	Rhematic Fever	

CONSENT: The undersigned hereby authorizes Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy which may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understood that a finance charge will be added to any overdue balance. I also assign all insurance benefits to the Doctor

PATIENT SIGNATURE (parent of child) _____ **Date**_____ **Dentist signature**_____

05-15-2013

Dental Associates of Lake Mills, Inc.

Dr. Jaclyn L. Benish D.D.S ● **Dr. Matthew J. Senn D.M.D**

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Patient Discounts Offered:
5% Payment Discount on estimated patient portion due on day of service
5% Senior Discount on estimated patient portion due on day of service (anyone 60 years or older)

PAYMENT AND BILLING POLICY

There will be a fee charged for dental services, additional procedures and follow-up appointments where applicable. A treatment plan will be presented to you at the end of your appointment explaining your estimated out of pocket cost.

Does my dental insurance cover all of your services? Dental insurance coverage varies widely. Not all policies cover the same type of services. It is your responsibility to understand what procedures are covered by your insurance.

We will make every attempt to contact your insurance carrier to verify eligibility and benefits. However, the eligibility and coverage information provided to us by your insurance carrier is subject to change during claims processing. Payment of claims is not guaranteed by our office or your insurance company at the time claim is processed. We will submit your claims for services on your behalf. By signing below, you authorize the insurance company to make the payment directly to Dental Associates of Lake Mills. **Any non-covered procedures including co-pays and deductibles will be your responsibility on the day of service.**

To ensure prompt processing of your claims, we need you to provide us with all dental insurance carrier information and any additional personal information required for filing your claim at the time of your initial visit. **Your insurance company and / or employer will not notify us of any changes, it is your responsibility to notify us of any changes, in your insurance status.**

What will I be expected to pay at the time of service if I do not have insurance? Payment in full is required at the day of service. We do offer several payment options.

How will I be billed? On the day of services, you will be asked to pay your estimated patient portion. We will as a courtesy submit your procedures to your insurance company. After insurance has cleared if a balance is still due a statement will be sent for the difference between the insurance company's payment (if not paid in full) and the charges for your procedures. This balance will be due upon receipt of the statement. Signing this document signifies that you have reviewed our payment and billing terms.

Print Name: _____ Signature: _____ Date: _____