

Health History Form

Referral Source (circle)

Drive by Family/friend Facebook
Insurance Website

E-mail: _____ 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:			Home Phone: <i>Include area code</i>	Business/Cell Phone: <i>Include area code</i>	
Last	First	Middle	()	()	
Address:			City:	State:	Zip:
Mailing address					
Occupation:			Height:	Weight:	Date of birth: Sex: M F
SS# or Patient ID:		Emergency Contact:	Relationship:	Home Phone: ()	Cell Phone: ()
			<i>Include area codes</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.....					
Persistent cough greater than a 3 week duration.....					
Cough that produces blood.....					
Been exposed to anyone with tuberculosis.....					
If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.					

Dental Information For the following questions, 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"/>
Does food or floss catch between your teeth?			<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"/>
Is your mouth dry?.....			<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 had any periodontal (gum) treatments?			<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 ever had orthodontic (braces) 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"/>
Have you had any problems associated with previous dental treatment?.....			<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"/>
Is your home water supply fluoridated?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you take aspirin daily?.....			<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? Circle one: DAILY / WEEKLY / OCCASIONALLY						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: _____			Phone: <i>Include area code</i>			If yes, what was the illness or problem?					
Address/City/State/Zip: _____						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"/>
Are you in good health?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements:					
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.

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

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

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?

Name of physician or dentist making recommendation: _____ Phone: _____

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: _____

FOR COMPLETION BY DENTIST

Comments: _____

**CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION
FOR THE PRACTICE OF CHARLES L. BARBER, D.M.D.**

SECTION A: PATIENT GIVING CONSENT

Print Name: _____

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign the Consent. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. Our Notice is posted. You may request a copy of our Notice of Privacy Practices including any revisions at any time by contacting:

Contact Person: Donna Kleemook Phone: 412-788-1911 Fax: 412-788-1911
Mailing Address: 6114 Steubenville Pike, McKees Rocks, PA 15136

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice Of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

Signature:

I have had full opportunity to read and consider the contents of the Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

Signed: _____ **Dated:** _____

If this Consent is signed by a representative on behalf of the patient complete the following:

Representative's Name: _____ Relationship to Patient: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

I have read and am aware that I may receive a copy if I so desire of this office's Notice of Privacy Practices.

Signed: _____ **Dated:** _____

For Office Use:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

Individual refused to sign Communications barrier An emergency situation Other

Explanation _____

FAILED APPOINTMENT AGREEMENT

We try faithfully to respect your valuable time by seating you promptly, unless emergency patients have delayed us.

When you do not show up for your scheduled appointment with either the Dentist or the Hygienist, three people lose:

1. You, the patient, do not receive the treatment you need.
2. The patient, who needs treatment immediately and cannot be seen due to a full schedule, loses because we are booked with your appointment.
3. We lose due to the fact that we cannot fill your lost time with anyone else.

You will receive notification of your appointment via text or email 21 days, 7 days and 3 days in advance and/or a phone call 2 days in advance if your appointment is not confirmed. **IF your appointment IS NOT confirmed within 24 hours of your appointment date, IT WILL BE REMOVED FROM OUR SCHEDULE.** _____(initials)

Our office operates on a very high hourly overhead cost basis. We scheduled your time with us just for you. When you do not show up, many people in our office are affected. **IF you fail to show for a confirmed appointment, please know you will be charged a broken appointment fee and that you are jeopardizing the Dentist/Patient relationship. The broken appointment fee with the Dentist is \$50. The broken appointment fee with the Hygienist is \$25.**

Patient Signature

Date

Office Signature

Date

FAILED APPOINTMENTS CAN RESULT IN PATIENT INACTIVATION

PLEASE COMPLETE OPPOSITE SIDE OF THIS FORM

Dear Patients:

Please take a few minutes to read over our office financial policy and **initial each item** in the left-hand margin area. **Upon completion, please sign.**

- Cash Patients/Patients Paying from a Fee Schedule

_____ 1. Our office is a fee for service office. As treatment is rendered, payment is to be made. There are no exceptions.

- Participating Insurance Plans

_____ 2. Our office will submit the completed treatment to your insurance company. All unpaid balances (deductible, co-insurance, etc.) are the patient's responsibility. Payment must be made to our office within 30 days to avoid a finance charge. All unpaid balances after 90 days will be submitted for collection.

- Non-Participating Insurance Plans

_____ 3. Our office will submit the completed treatment to your insurance company, yet to minimize or avoid billing the following percentage of the cost of your treatment will be paid at the time of service: Crowns, Bridges, Partials and Dentures – 100%

I have read and agree to the above guidelines.

Patient Signature

Date

Office Manager Signature

Date

OFFICE POLICIES

1. A 24-hour notice is required to change or cancel all dental appointments. Not giving the 24-hour notice constitutes a failed appointment. Two failed appointments could result in patient inactivation.
2. Our practice has replaced the amalgam (silver fillings) with more functional esthetic materials which we use exclusively. These materials:
 - Break down less
 - Cause less tooth sensitivity
 - Wear more like enamel
 - Match your tooth color

Due to the complexity of these materials, several procedural steps must be taken when placing them. Thus additional costs are incurred. The quality of these restorations far exceeds the minimal costs.

3. I hereby authorize and consent Charles L. Barber, DMD and those qualified perform the treatment plan as explained. I understand that failure to complete restorative and preventative treatment can result in pain and possible tooth loss.

I have read and I understand the above policies.

Patient Signature

Date

Doctor Signature

CHARLES L. BARBER, DMD

GENERAL AND COSMETIC DENTISTRY

6114 Steubenville Pike
McKees Rocks, PA 15136

Patient Evaluation Form of _____
Patient name and date

We understand how much the appearance of your teeth can affect your overall contentment, happiness, and confidence in the way you feel about yourself. Please answer the following so that we may help you achieve these feelings:

PLEASE CIRCLE YOUR RESPONSE

1. Do you like the appearance of your teeth?
Yes or No
2. Overall, do you like the appearance of your smile?
Yes or No
3. Are your teeth all in alignment (straight)?
Yes or No
4. Do you have spaces between your teeth that you do not like?
Yes or No
5. Do you like the color of your teeth?
Yes or No
6. Do you like the shape of your teeth?
Yes or No
7. Are your teeth chipped, broken or protruding?
Yes or No
8. Are your teeth worn down on the biting surfaces or near the gum line?
Yes or No
9. Do you have any crowns or bridges that appear dark at the edge of your gums?
Yes or No
10. What would you like to change the most about your smile? How would you like your teeth to look?
