Health History Form

E-mail: Today's Date:

Referral Source *(circle)*

Drive by Family/friend Facebook
Insurance Website

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

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
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Does food or floss catch between your teeth?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐
Do you drink bottled or filtered water?	☐	☐	☐
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY			
Are you currently experiencing dental pain or discomfort?	☐	☐	☐

	Yes	No	DK
Do you have earaches or neck pains?	☐	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Do you brux or grind your teeth?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Do you participate in active recreational activities?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐
Do you take aspirin daily?	☐	☐	☐

Date of your last dental exam:
What was done at that time?
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
Are you now under the care of a physician?	☐	☐	☐

Physician Name: Phone: *Include area code* ( )

Address/City/State/Zip:

	Yes	No	DK
Are you in good health?	☐	☐	☐
Has there been any change in your general health within the past year?	☐	☐	☐

If yes, what condition is being treated?

Date of last physical exam:

	Yes	No	DK
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐	☐

If yes, what was the illness or problem?

	Yes	No	DK
Are you taking or have you recently taken any prescription or over the counter medicine(s)?	☐	☐	☐

If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements:

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Form S500

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

(Check DK if you Don't Know the answer to the question) — Yes / No / DK

Do you wear contact lenses? ☐ ☐ ☐

Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? ☐ ☐ ☐
Date: ____________ If yes, have you had any complications? ____________

Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease? ☐ ☐ ☐

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? ☐ ☐ ☐
Date Treatment began: ____________

Do you use controlled substances (drugs)? ☐ ☐ ☐

Do you use tobacco (smoking, snuff, chew, bidis)? ☐ ☐ ☐
If so, how interested are you in stopping?
(Circle one) VERY / SOMEWHAT / NOT INTERESTED

Do you drink alcoholic beverages? ☐ ☐ ☐
If yes, how much alcohol did you drink in the last 24 hours? ____________
If yes, how much do you typically drink In a week? ____________

WOMEN ONLY Are you:
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
To all **yes** responses, specify type of reaction.

Allergy	Yes	No	DK
Local anesthetics	☐	☐	☐
Aspirin	☐	☐	☐
Penicillin or other antibiotics	☐	☐	☐
Barbiturates, sedatives, or sleeping pills	☐	☐	☐
Sulfa drugs	☐	☐	☐
Codeine or other narcotics	☐	☐	☐
Metals	☐	☐	☐
Latex (rubber)	☐	☐	☐
Iodine	☐	☐	☐
Hay fever/seasonal	☐	☐	☐
Animals	☐	☐	☐
Food	☐	☐	☐
Other	☐	☐	☐

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

Condition	Yes	No	DK
Artificial (prosthetic) heart valve	☐	☐	☐
Previous infective endocarditis	☐	☐	☐
Damaged valves in transplanted heart	☐	☐	☐
Congenital heart disease (CHD)			
Unrepaired, cyanotic CHD	☐	☐	☐
Repaired (completely) in last 6 months	☐	☐	☐
Repaired CHD with residual defects	☐	☐	☐

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

Condition	Yes	No	DK
Cardiovascular disease.	☐	☐	☐
Angina	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Congestive heart failure	☐	☐	☐
Damaged heart valves	☐	☐	☐
Heart attack	☐	☐	☐
Heart murmur	☐	☐	☐
Low blood pressure	☐	☐	☐
High blood pressure	☐	☐	☐
Other congenital heart defects	☐	☐	☐
Mitral valve prolapse	☐	☐	☐
Pacemaker	☐	☐	☐
Rheumatic fever	☐	☐	☐
Rheumatic heart disease	☐	☐	☐
Abnormal bleeding	☐	☐	☐
Anemia	☐	☐	☐
Blood transfusion	☐	☐	☐
If yes, date: ____________			
Hemophilia	☐	☐	☐
AIDS or HIV infection	☐	☐	☐
Arthritis	☐	☐	☐
Autoimmune disease	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Systemic lupus erythematosus.	☐	☐	☐
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐
Tuberculosis	☐	☐	☐
Cancer/Chemotherapy/ Radiation Treatment	☐	☐	☐
Chest pain upon exertion	☐	☐	☐
Chronic pain	☐	☐	☐
Diabetes Type I or II	☐	☐	☐
Eating disorder	☐	☐	☐
Malnutrition	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
G.E. Reflux/persistent heartburn	☐	☐	☐
Ulcers	☐	☐	☐
Thyroid problems	☐	☐	☐
Stroke	☐	☐	☐
Glaucoma	☐	☐	☐
Hepatitis, jaundice or liver disease	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Neurological disorders	☐	☐	☐
If yes, specify: ____________			
Sleep disorder	☐	☐	☐
Mental health disorders	☐	☐	☐
Specify: ____________			
Recurrent Infections	☐	☐	☐
Type of infection: ____________			
Kidney problems	☐	☐	☐
Night sweats	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistent swollen glands in neck	☐	☐	☐
Severe headaches/ migraines	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
Excessive urination	☐	☐	☐

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: ____________

HIPPA Compliance Patient Consent Form for the Practice of *CHARLES L. BARBER D.M.D.*

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patients' rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPPA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your dental condition with any member of your family? YES NO

If YES, please name the members allowed:

____

____

This consent was signed by: ____

(PRINT NAME PLEASE)

Signature: ____________________________________ Date: ___________________________

Witness: _____________________________________ Date: ___________________________

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

Charles L. Barber, DMD

6114 Steubenville Pike
Robinson Township
McKees Rocks, PA 15136

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

PLEASE SEE OTHER SIDE.

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 DENTISTY
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?

____

____

____