

# CENTENNIAL HILLS DENTAL HEALTH CENTRE

## PATIENT INFORMATION

DATE \_\_\_\_\_

NAME \_\_\_\_\_  Married  Single  Minor  Male  Female  
LAST FIRST MADDRESS \_\_\_\_\_  
STREET APT# CITY STATE ZIPBIRTHDATE \_\_\_\_\_ TELEPHONE NO \_\_\_\_\_  
MONTH DAY YE AR CELLULAR HOME

SS# \_\_\_\_\_ EMAIL ADDRESS \_\_\_\_\_ WORK PHONE NO \_\_\_\_\_

PERSON RESPONSIBLE FOR ACCOUNT- PLEASE CHECK ONE:  PATIENT  GUARDIAN  SPOUSE  FATHER  MOTHER**INSURANCE INFORMATION** MINOR CHILD MAY NEED TO COMPLETE BOTH BLOCK FOR PARENT INFORMATION  
ADULTS COMPLETE PRIMARY INSURED  
DUAL COVERAGE? ALSO COMPLETE SECOND INSURED

PRIMARY INSURED / IF NO INSURANCE COMPLETE FOR RESPONSIBLE PARTY			
LAST	FIRST	M	
STREET	CITY	STATE	ZIP
CELLULAR#	WORK#	HOME#	EMAIL
BIRTHDATE (M/D/Y)	RELATIONSHIP TO PATIENT		
EMPLOYER	DENTAL INSURANCE CO		
SS#	SUBSCRIBER#	GROUP#	

SECONDARY INSURED			
LAST	FIRST	M	
STREET	CITY	STATE	ZIP
CELLULAR#	WORK#	HOME#	EMAIL
BIRTHDATE (M/D/Y)	RELATIONSHIP TO PATIENT		
EMPLOYER	DENTAL INSURANCE CO		
SS#	SUBSCRIBER#	GROUP#	

## PERSON TO CONTACT IN CASE OF EMERGENCY OUTSIDE OF IMMEDIATE FAMILY HOUSEHOLD

NAME ADDRESS CITY STATE ZIP TELEPHONE#

HAS ANY MEMBER OF YOUR FAMILY EVER BEEN TREATED IN OUR OFFICE?

 YES  NO

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?

## AUTHORIZATION

I hereby authorize payment directly to Centennial Hills Dental Health Centre of the group insurance benefits otherwise payable to me. I understand that I am responsible for all cost of dental treatment. I hereby authorize Centennial Hills Dental Health Centre to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/ medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical/ histories and other information about my dental treatment to third party payors and/or other health professionals.

X \_\_\_\_\_ DATE \_\_\_\_\_  
STATE & DRIVERS LICENSE# \_\_\_\_\_

## METHOD OF PAYMENT

Responsible party currently has account with this office  YES  NO Payment in full at each appointment (cash or personal check) Payment in full at each appointment ( Visa  MC  Other)

Card# \_\_\_\_\_ Exp. Date \_\_\_\_\_

 I wish to discuss the Dentals office's Financial Policy

## SERVICE CHARGE

If you do not pay the entire new balance within **30** days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of **1.5%** per month (or a minimum charge of \$20.00 for a balance under \$100.00) which is an annual percentage rate of **18%** applied to the last months balance. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection cost and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

X \_\_\_\_\_ DATE \_\_\_\_\_  
STATE & DRIVERS LICENSE # \_\_\_\_\_

# CENTENNIAL HILLS DENTAL HEALTH CENTRE

PATIENT NAME \_\_\_\_\_ DATE \_\_\_\_\_

Primary reason for this dental appointment  Examination  Emergency  Consultation

**DENTAL HISTORY**

please circle

Do you have a specific dental problem? Describe \_\_\_\_\_ Yes No  
 Do you have a dental examination on a regular basis? Last visit \_\_\_\_\_ Yes No  
 Do you think you have active decay or gum disease? \_\_\_\_\_ Yes No  
 Do you brush and floss on a routine basis? Discuss \_\_\_\_\_ Yes No  
 Do your gums ever bleed? Discuss \_\_\_\_\_ Yes No  
 Do you like your smile? Why? \_\_\_\_\_ Yes No  
 Does food catch between your teeth? Any loose teeth? \_\_\_\_\_ Yes No  
 Do you want to keep your remaining teeth? \_\_\_\_\_ Yes No  
 Do you ever have clicking, popping or discomfort in the jaw? Do you brux or grind? \_\_\_\_\_ Yes No  
 Have your past experiences in a dental office been positive? \_\_\_\_\_ Yes No  
 Do you smoke or chew? Any sores or growths in your mouth? Discuss \_\_\_\_\_ Yes No  
 Name of previous Dentist (optional) \_\_\_\_\_  
 Date of last full mouth x-ray (16 small films or panoramic) \_\_\_\_\_

**MEDICAL HISTORY**

Are you under a physician's care now? Why? \_\_\_\_\_ Who? \_\_\_\_\_ Phone # \_\_\_\_\_ Yes No  
 Have you ever been hospitalized or had a major operation? Discuss \_\_\_\_\_ Yes No  
 Have you ever had a serious injury to your head or neck? Discuss \_\_\_\_\_ Yes No  
 Are you taking any medications, pills or drugs? What? \_\_\_\_\_ Ever taken fen-phen? \_\_\_\_\_ Yes No  
 Are you on a special diet? Discuss \_\_\_\_\_ Yes No  
 Are you allergic to any medications or substances? Please check box below \_\_\_\_\_ Yes No  
 Aspirin  Penicillin  Codeine  Acrylic  Metal  Latex Rubber  Other \_\_\_\_\_  
 Women (please check)  Pregnant/ trying to get pregnant  Nursing  Taking oral contraceptives Discuss \_\_\_\_\_ Yes No

Do you now or have or have you ever had any of the following? Please check appropriate boxes.

\*If yes to any of the stated conditions, please call prior to your appointment...premedication may be required.

	Yes No	Yes No	Yes No	Yes No	Yes No
Heart trouble/ Disease	<input type="checkbox"/> Bruise Easily	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Yellow Jaundice	<input type="checkbox"/> Cold Sores	<input type="checkbox"/>
Heart Murmur *	<input type="checkbox"/> Anemia	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> Fever Blisters	<input type="checkbox"/>
Irregular Heart Beat	<input type="checkbox"/> Excessive Bleeding	<input type="checkbox"/> Cancer	<input type="checkbox"/> Renal Dialysis	<input type="checkbox"/> Herpes	<input type="checkbox"/>
Angina/ Chest Pain	<input type="checkbox"/> Sickle Cell Disease	<input type="checkbox"/> X-Ray Treatments (Radiation)	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Convulsions	<input type="checkbox"/>
Heart Attack/ Failure	<input type="checkbox"/> Blood Sputum	<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> Parathyroid Disease	<input type="checkbox"/> Epilepsy or Seizures	<input type="checkbox"/>
Congenital Heart Disorder	<input type="checkbox"/> Hemophilia (bleeding disorder)	<input type="checkbox"/> Stomach/ Intestinal Disease	<input type="checkbox"/> Arthritis/ Gout	<input type="checkbox"/> Faint or Dizziness	<input type="checkbox"/>
Mitral Valve Prolapse*	<input type="checkbox"/> Leukemia	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Rheumatism	<input type="checkbox"/> Stroke	<input type="checkbox"/>
Scarlet Fever	<input type="checkbox"/> Recent Blood Transfusion	<input type="checkbox"/> Recent Weight Loss	<input type="checkbox"/> Pain in Jaw Joints	<input type="checkbox"/> Convulsions	<input type="checkbox"/>
Rheumatic Fever*	<input type="checkbox"/> Swelling of Limbs	<input type="checkbox"/> Frequent Diarrhea	<input type="checkbox"/> Cortisone Medicine	<input type="checkbox"/> Glaucoma	<input type="checkbox"/>
Artificial Heart Valve*	<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Artificial Joint*	<input type="checkbox"/> Tumors or Growth	<input type="checkbox"/>
Heart Pace Maker*	<input type="checkbox"/> Breathing Problems	<input type="checkbox"/> Excessive Thirst	<input type="checkbox"/> Venereal Disease	<input type="checkbox"/> Nervousness	<input type="checkbox"/>
Heart Surgery	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> AIDS	<input type="checkbox"/> Psychiatric Care	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/> Frequent Cough	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> HIV Positive	<input type="checkbox"/> Alzheimer's Disease	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Hepatitis A (Infectious)	<input type="checkbox"/> Genital Herpes	<input type="checkbox"/> Allergies (Pollen/ Dust)	<input type="checkbox"/>
Blood Diseases	<input type="checkbox"/> Sinus Trouble	<input type="checkbox"/> Hepatitis B or C	<input type="checkbox"/> Drug Addiction/ Alcoholism	<input type="checkbox"/> Hives or Rash	<input type="checkbox"/>
Unexplained Fever	<input type="checkbox"/> Asthma	<input type="checkbox"/> Night Sweats	<input type="checkbox"/> tattoos	<input type="checkbox"/> Need Premedication?	<input type="checkbox"/>

Have you ever had any other serious illness not checked above? Discuss \_\_\_\_\_ Yes No

Do you wish to talk to the Dentist privately about any problem? \_\_\_\_\_ Yes No

X \_\_\_\_\_ Date \_\_\_\_\_

PATIENT SIGNATURE (PARENT OR GUARDIAN)

Reviewed by Doctor \_\_\_\_\_ Date \_\_\_\_\_ BP \_\_\_\_\_

