Healthy Smiles Health History

Patient's Name_____

Are you in good health…… Yes No
Has there been any change in your health
within the past year…….. Yes No
Date of last physical exam_____
Who is your primary care physician_____
Are you now under medical care…… Yes No
If so, for what?_____
Have you ever had a serious illness
or operation…….. Yes No
If so, for what?_____
Who is your primary pharmacy_____

***Do you have or have you ever had any of the following?**

Allergies, hay fever, skin rash, hives…….. Yes No
Arthritis (rheumatoid or osteo)…….. Yes No
Delay in healing…….. Yes No
Infective Endocarditis…… Yes No
Stroke…….. Yes No
High Blood Pressure…… Yes No
Epilepsy or Seizure Disorder…….. Yes No
Fainting Spells…….. Yes No
Infectious mononucleosis…….. Yes No
Hepatitis, Jaundice, or Liver Disease…….. Yes No
Immune System Depression
Organ transplant, AIDS, HIV…… Yes No
Have you ever had surgery, radiation or
chemotherapy, for a tumor growth…… Yes No
Diabetes…… Yes No
Rheumatic Fever…… Yes No
Ulcers (Stomach or Intestinal/Acid Reflux) Yes No
Do your ankels swell…….. Yes No
Blood disorder such as anemia…….. Yes No
Bruise easily…….. Yes No
Gallbladder trouble…….. Yes No
Low blood sugar…….. Yes No
Kidney trouble…….. Yes No
Are you on dialysis…….. Yes No
High cholesterol…….. Yes No
Osteoporosis/osteopenia…….. Yes No
Osteonecrosis…….. Yes No
Contagious diseases…… Yes No
Sexually transmitted diseases…… Yes No
Mental health problems/anxiety/depression Yes No
Chronic fatigure/night sweats…….. Yes No
Do you have implants?
(Breast, Penile, etc.)…….. Yes No
Do you have a history of artifical joints…… Yes No
If so, what type and date_____
Tuberculosis…….. Yes No
Persistent cough or cough up blood…….. Yes No
Sinus problems…….. Yes No
Snoring/sleep apnea…….. Yes No
Difficult breathing/other lung trouble…….. Yes No
Asthma/Emphysema…….. Yes No
Do you use a CPAP machine…….. Yes No
Do you use supplemental oxygen…….. Yes No
*Women Only: Are you pregnant…….. Yes No
Have you ever taken diet pills…… Yes No

***Have you had, or do you have the following cardiac conditions?**

Damaged heart valves or mitral
valve prolapse…….. Yes No
Chest pain/angina…….. Yes No
Irregular heart beat…… Yes No
Cardiac pacemaker…… Yes No
Heart bypass surgery…… Yes No
Cardiovascular Disease…….. Yes No
Artifical Heart Valves…… Yes No

***Dental History**

Have you had abnormal bleeding associated
with previous surgery or extractions…… Yes No
Removable dental appliance…….. Yes No
Pain or clicking of jaws when eating…… Yes No
Nightguard/Occlusal Splint…… Yes No
Have you had any serious trouble associated
with any previous dental treatment…… Yes No
*Date of last dental exam_____
*Have you ever had gum disease…… Yes No
*Have you been satisifed with your
previous dental treatment…… Yes No
If no, please explain_____
_____
*Reason for seeking treatment_____

***Are you allergic to or have you ever reacted adversely to any of the following?**

Local anesthetics (novocaine, etc)…….. Yes No
Penicillin…… Yes No
Other antibiotics…….. Yes No
Sulfa drugs…….. Yes No
Sodium pentothal/Valium or other tranquilizers…… Yes No
Aspirin…….. Yes No
Amoxicillin…….. Yes No
Codeine or other narcotics…… Yes No
Other medications…… Yes No
Please List:_____
Latex…… Yes No
Soy…… Yes No
Eggs/Yolk…….. Yes No
Sulfites…….. Yes No
Do you have any known allergies…….. Yes No
Please list any allergies other than drug allergies
_____

***Are you taking any of the following?**

Antibiotics or antiviral medicine…… Yes No
Anticoagulants (Blood Thinners)
Coumadin, Plavix, Asprin, Vitamin E, Ginko Biloba, Aggrenox, Pradaxa, Fish Oil Yes No
Antidepressants
Tranquilizers, sleeping pills, anti-depressants, and/or narcotics on a regular basis…….. Yes No
Please list:_____
Antidiabetic Medicine (Insulin, etc.)…….. Yes No
Antabuse…….. Yes No
Birth Control Pills/Patch, etc…… Yes No
Cortisone or Steorids…… Yes No
Digoxin or drugs for heart trouble…….. Yes No
Dilantin or other seizure medicine…….. Yes No
Medicine for high blood pressure…… Yes No
Narcotic Anagesic…… Yes No
Nitroglycerin…… Yes No
Any natural product, herbal supplement or homeopathic remedy…… Yes No
Are you taking, or have you ever taken bone density medication or bisposphonates such as Fosamax, Boniva, Actonel, IV-Zometa, Aredia, Zgeva, Prolia or Reclast in the past 12 years…….. Yes No

***Do you have a history of the following?**

Substance Abuse
Alcoholism or drug addiction…….. Yes No
Active or recovering…… Yes No
Recreational drugs or substances…….. Yes No
Do you smoke…….. Yes No
If so, how many packs a day_____
Do you use chewing tobacco…… Yes No

***Do you have any other medical conditions not included above? Please list and describe:**

_____
_____
_____
_____
_____
_____
_____
_____
_____

***Please list any medication you are currently taking and dosages:**

_____
_____
_____
_____
_____
_____
_____
_____

_____ _____
Signature Date

Healthy Smiles Office Policies

Please read and sign this form. If you have any questions, please ask for assistance.

Financial Policy Payment is due at the time services are rendered. We accept cash, check, Mastercard, and Visa. As a courtesy to our patients, we do take care of insurance billing. Co-payments and co-insurances are due at the time services are rendered. For extensive treatments, payment plans may be arranged with the office manager. Patients may review a treatment plan before treatment is initiated. Treatment plan prices will be guaranteed for 6 months from the treatment plan date. For crowns, bridges and other major work, a partial payment will be required when treatment begins with the balance due when treatment is completed.

Regular Visits Regular preventative care is very important in maintaining long lasting dental health, so we encourage our patients to adhere to the recommended visits. We will advise you when it is time for your next visit, and help you with appointments that best suit your busy schedule.

Appointments We strive to keep our patients' waiting time to a minimum, as we recognize that your time is valuable. Therefore, we are able to see our patients on an appointment basis only. We consider an appointment made to be an agreement and commitment between our office and our patients.

Emergencies As emergencies do arise, we ask your patience. If there is a delay during your appointment time due to a patient in need of immediate care, we will try and inform you of any changes necessary ahead of time, if possible. If you have an emergency, please call the office right away and we will do everything possible to get you in at the earliest opportunity.

"No Shows" and Cancellations A scheduled appointment is a commitment of time between the doctor and the patient. We have reserved that time just for you. When appointments are missed or cancelled, that time is lost. We ask that when you schedule your treatment, you make every effort to keep that commitment. A 24-hour notice will allow us to schedule another patient in need of treatment. **It is our policy that with less than 24-hours notice on a change of commitment, a charge will be considered and could be applied to your account.**

Signature_____

Today's Date_____

Healthy Smiles Family Dentistry
Spirit Lake, IA 51360
Brandy Lancaster, D.D.S.

Thank you for choosing our practice for your dental needs. Please complete and sign this form. If you have any questions, please ask for assistance.

PATIENT DATA

Patient's Name-First, MI, Last_____

Patient's Address_____City_____State_____Zip_____

Home Phone_____Email Address_____

Employer_____Work Phone_____

Cell Phone_____ Male_____ Female_____

Are you *(Circle One)* Minor Single Married Separated Divorced Widowed

Patient's Birthdate_____/_____/_____ Patient's Social Security #_____-_____-_____

EMERGENCY CONTACT

Full Name-First, MI, Last_____Relationship_____Phone_____

PERSON RESPONSIBLE FOR PAYMENT (Please complete if other than the patient)

Full Name-First, MI, Last_____Social Security #_____-_____-_____ Birthdate_____

Patient's Address_____City_____State_____Zip_____

Employer_____Work Phone_____City_____

	Primary Dental Insurance	**Secondary Dental Insurance**
Insurance Company	_____	_____
Insured Person's Name	_____	_____
Social Security #	_____	_____
Group or Policy #	_____	_____

AGREEMENT

I hereby authorize the dentist to take X-rays, study models, photographs or any aid deemed appropriate by the dentist in charge of my care to make a thorough diagnosis of my (or the patient's) dental needs.

I also authorize the dentist to perform any and all forms of treatment, medication and therapy that may be indicated.

I authorize and request by insurance company to pay directly to the dentist. I understand that my dental insurance carrier may pay less than the actual bill for services that the dentist provided. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature_____**Date**_____

HEALTHY SMILES FAMILY DENTISTRY

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____ have received a copy of the Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

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

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)
