

## DENTAL HEALTH HISTORY

H. Name of your previous Dentist: \_\_\_\_\_ How long since you were last seen? \_\_\_\_\_

68. Is keeping your teeth important to you? Yes No If yes, why? \_\_\_\_\_

69. On a scale of 1-10, 10 being the best, where would you rate your smile?

70. On a scale of 1-10, 10 being the best, where would you rate your oral health?

71. Have you experienced any of the following problems:

Bleeding gums	Yes	No	Sensitivity to Hot & Cold	Yes	No
Bad Breath or sour taste in mouth	Yes	No	Snoring	Yes	No
Burning sensations in mouth	Yes	No	Food catching between teeth	Yes	No
Soreness in jaw	Yes	No	Grinding of Teeth	Yes	No
Is it hard for you to open wide?	Yes	No	Pain/soreness around ears, eyes, face	Yes	No
Clicking or popping in jaw	Yes	No	Stiff neck muscles	Yes	No
Had your parents suffered from Gum Disease?	Yes	No	Did your parents wear dentures/partials?	Yes	No
Did you ever wear braces?	Yes	No	Ever been injured in your mouth or head?	Yes	No
Oral Surgery of any kind?	Yes	No	Do you smoke or chew tobacco?	Yes	No

72. Does having dental treatment make you afraid or nervous? Yes No If yes, what specific things bother you?  
\_\_\_\_\_

73. Is the brightness of your teeth important to you? Yes No

74. If you could change anything about your smile which of the following would you want?

Whiter	Yes	No	Close space or spaces	Yes	No	Replace chipped teeth	Yes	No
Replace missing teeth	Yes	No	Replace old crowns	Yes	No	Remove silver fillings	Yes	No
Remove Stains/Spots on teeth	Yes	No	Excess showing of Teeth	Yes	No	Replace old plastic fillings	Yes	No
Straighter	Yes	No	Less Gum showing	Yes	No	Reshape/resize my teeth	Yes	No

75. Fill in this question for us please: Where do you see your overall oral health and/or your smile in the next 5 to 10 years?  
\_\_\_\_\_

Please circle the following which are important to you when making your dental health decision.

Convenience	Appearance	Relationship with Dental Team
Finances	Time	Quality of care
What insurance covers	Health	Detailed treatment explanations
Fear or Anxiety	Comfort	Technology

STAN K. BRADY, D.D.S.  
Family Dentistry

## GENERAL & COSMETIC DENTISTRY

**Welcome to our Practice!**

Will you please help us by providing us with the following confidential information?

### PATIENT INFORMATION:

E-mail Address: \_\_\_\_\_ Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Preferred to be called: \_\_\_\_\_ Mailing Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

SS#: \_\_\_\_\_ Driver's License: \_\_\_\_\_ Sex: M F Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_ Address, City, State, Zip \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Spouse's Address (if different than above): \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_ Address, City, State, Zip \_\_\_\_\_

**In the event that we must contact you for scheduling changes, etc., please indicate the best PHONE NUMBER during business hours to phone you:**

Phone number: \_\_\_\_\_ Place \_\_\_\_\_ Time: \_\_\_\_\_

### INSURANCE INFORMATION:

Primary Insurance Company: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone #: \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_ SS#: \_\_\_\_\_ Birth date: \_\_\_\_\_

Group # or Policy #: \_\_\_\_\_

**Our office will file and accept assignment of benefits from your Primary Insurance Company. The patient will be responsible for any remaining balance. If the patient has Secondary Insurance, we will assist you in filing the claim and the benefit will be assigned to the patient. We do not wait on nor directly accept benefits from Secondary Insurance.**

I hereby authorize the release of any information to my insurance company or companies, including records of examinations, diagnosis and/or treatment. This release is solely for the purpose of facilitating the billing and reimbursement, directly to Dr. Brady of insurance benefits under which I am entitled. I hereby agree that I am financially responsible for all treatment rendered, and understand that complete payment will be made after each treatment, unless other financial arrangements have been previously arranged.

Date: \_\_\_\_\_ Patient's Signature: \_\_\_\_\_

HIPAA PRIVACY FORM

Acknowledgment of Receipt of Notice of Privacy Practices

Purpose: This form is used to obtain acknowledgment of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgment.

\*\* You may refuse to sign this acknowledgment \*\*

I, \_\_\_\_\_, have received a copy/explanation of this office's Notice of Privacy Practices.

(Signature of Patient and/or Guardian) \_\_\_\_\_ (Date) \_\_\_\_\_

(Relationship to Patient) Self \_\_\_\_\_ or Other: \_\_\_\_\_

For Office Use Only

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

Individual refused to sign

Communications barriers (such as a language barrier) prohibited obtaining the acknowledgment

An emergency situation prevented us from obtaining acknowledgment at time of service

Other (Please specify)

MEDICAL HEALTH HISTORY

PATIENT NAME: \_\_\_\_\_

A. CIRCLE YOUR ANSWERS (leave BLANK if you do not understand the question):

- 1. Yes No Are you in good health?
2. Yes No Has there been a change in your health within the last year? Explain:
3. Yes No Have you been hospitalized or had a serious illness in the last 5 years? Explain:
4. Yes No Are you being treated by a physician now? For what?

Name of your physician: \_\_\_\_\_ Date of last Medical Exam: \_\_\_\_\_

B. HAVE YOU EVER EXPERIENCED:

- 5. Yes No Chest Pains
6. Yes No Swollen Ankles
7. Yes No Shortness of breath
8. Yes No Recent weight loss, fever, night sweats
9. Yes No Persistent cough, coughing up blood
10. Yes No Bleeding problems, bruising easily
11. Yes No Sinus Problems
12. Yes No Difficulty swallowing
13. Yes No Diarrhea, constipation, blood in stools
14. Yes No Frequent vomiting nausea
15. Yes No Difficulty urinating, blood in urine
16. Yes No Dizziness
17. Yes No Ringing in ears
18. Yes No Frequent Headaches
19. Yes No Fainting spells
20. Yes No Blurred Vision
21. Yes No Seizures
22. Yes No Excessive thirst
23. Yes No Frequent urination
24. Yes No Dry Mouth
25. Yes No Jaundice
26. Yes No Joint pain, stiffness
27. Yes No Sleep apnea or chronic snoring

C. DO YOU HAVE OR HAVE YOU HAD:

- 28. Yes No Heart disease
29. Yes No Heart attack, heart defects
30. Yes No Heart murmur
31. Yes No Rheumatic fever
32. Yes No Stroke, hardening of arteries
33. Yes No High Blood Pressure
34. Yes No TB, emphysema or other lung diseases
35. Yes No Hepatitis, A B C
36. Yes No Stomach problems, ulcers
37. Yes No Diabetes
38. Yes No Family History of diabetes, heart problems, cancer
39. Yes No HIV positive or AIDS-ARC
40. Yes No Tumors, Cancer
41. Yes No Arthritis, rheumatism
42. Yes No Eye disease
43. Yes No Skin disease
44. Yes No Anemia
45. Yes No VD (syphilis or gonorrhea)
46. Yes No Herpes
47. Yes No Kidney, bladder diseases
48. Yes No Thyroid, adrenal diseases
49. ALLERGIES: to drugs, food, medications, metals, jewelry, acrylics; list the following allergies:

D. DO YOU HAVE OR HAVE YOU HAD:

- 50. Yes No Surgeries
51. Yes No Blood Transfusions
52. Yes No Artificial Joint
53. Yes No Contact Lenses
54. Yes No Psychiatric Care
55. Yes No Radiation Treatments
56. Yes No Chemotherapy
57. Yes No Prosthetic heart valve
58. Yes No Pacemaker
59. Yes No Women only: Birth Control Pills
60. Yes No Women only: Pregnant or nursing

VITAMINS & MEDICATIONS:

E. DO YOU TAKE OR HAVE TAKEN:

- 61. Yes No Recreational drugs
62. Yes No Alcohol
63. Yes No Tobacco in any forms
64. Yes No Phen Phen diet Pills or any other diet pills
65. Yes No Fosamax

F. ALL PATIENTS:

- 66. Yes No Do you have or have you had any other diseases or medical problems NOT listed on this form? If so, please explain:
67. Yes No Have you ever been told by a physician or dentist that you need to pre-medicated prior to any dental treatment?