Health History Form

ADA American Dental Association®
America's leading advocate for oral health

Email: 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: *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: *Include area code* ( ) Cell Phone: *Include area code* ( )
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 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?	☐	☐	☐
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?	☐	☐	☐

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:			
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?			
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 dietary supplements:			

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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 an antiresorptive agent (like Fosamax®, Actonel®, Atelvia, Boniva®, Reclast, Prolia) for osteoporosis or Paget's disease?	☐	☐	☐
Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia®, Zometa®, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?	☐	☐	☐
Date Treatment began: _____			

	Yes	No	DK
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 i n 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:
To all **yes** responses, specify type of reaction.

	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.

	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.

	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	☐	☐	☐

	Yes	No	DK
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	☐	☐	☐

	Yes	No	DK
Glaucoma	☐	☐	☐
Hepatitis, jaundice or liver disease	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Neurological disorders	☐	☐	☐
If yes, specify: _____			
Sleep disorder	☐	☐	☐
Do you snore?	☐	☐	☐
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	☐	☐	☐

	Yes	No	DK
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	☐	☐	☐

Name of physician or dentist making recommendation:

Phone: *Include area code*
( )

	Yes	No	DK
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:

Signature of Dentist: Date:

FOR COMPLETION BY DENTIST

Comments:

Christopher Chan, D. D. S.

Getting to know you …

Patient Name _____ Date_____

To help us serve your dental needs best, we would like to know more about you. Please take a moment to complete the following questions:

What do you expect from your dental visit with us today?

_____

_____

What is most important to you about your dental health?

_____

_____

In your opinion, what is the present condition of your mouth?

_____

_____

Are you aware that there are medical conditions related to dental disease?

_____

_____

What do you know about periodontal disease?

_____

_____

If you could "enhance" anything about your smile, what would that be?

_____

_____

Are there any foods you enjoy but can not eat due to discomfort with your teeth?

_____

_____

What has been your overall experience in other dental offices?

_____

_____

Has "fear" or "cost" ever prevented you from getting the dental treatment you need? Y __N__or Want? Y__N__ Please explain:_____

_____

Should you be in need of treatment, at what point do you plan to "get started"? Please circle:
A) When it hurts B) When it breaks C) When it is recommended in order to prevent further deterioration

How did you hear about our office? (Please circle all that apply) 1-800-dentist -yelp Yellow Pages - Internet-Website –N.Mag- Saw our sign- Friend/Family-Other_____

Please feel free to let us know more about how we can help make this your best dental experience._____

_____

CROWN DENTISTRY
CHRISTOPHER CHAN, D.D.S
4450 Duckhorn Drive Suite A
Sacramento, CA. 95834
(916) 285-9678

MISSED APPOINTMENT POLICY

Our office staff is diligent in finding an appointment time and day that would best meet your scheduling needs as well as our availability. Once you have made an appointment this is ***your reserved time*** with Dr. Chan and / or the Hygienist. If for any reason you need to cancel, you MUST GIVE AT LEAST A 2 BUSINESS DAY notice. The fee for a missed appointment is $50. However we are aware if unforeseen emergencies that may occur and in the event please notify the office as soon as possible.

****In addition please note; any appointment not confirmed 2-business days prior to the scheduled appointment date through email or by telephone, is subject to cancellation and may be considered open to another patient.*

By signing below you indicate that you I have read and understand the above policy and missed appointment fees that may result.

_____ _____
Signature Date

_____ _____
Parent / Guardian (for any patient under age 18) Date

OFFICE POLICIES
Christopher Chan D.D.S.

Our philosophy is to provide the highest quality of patient education and dental care to all of our patients. To ensure you begin with a positive experience we have prepared the following information for your review. Please feel free to let us know if you have any questions or concerns.

DENTAL INSURANCE:
We are happy to file your dental insurance claims to assist you in receiving the full benefits of your coverage. We request you familiarize yourself with your insurance benefits, and provide us the correct information to assist you with the submittal of claims. We will accept the estimated insurance payment directly from your insurance company provided payment is received from them within 45-60 days. Please remember, your insurance is a contract between you, your employer, and the insurance company; therefore, you are ultimately responsible for the total amount of your dental fees. The treatment recommended for you is clinically ideal regardless of your insurance benefits, deductibles, limitations, or maximums.

_____
Initials

EXPECTED PAYMENT
To keep our fees to you as low as possible, we ask that your estimated co-payment be made in full at the time of service. For your convenience you will be provided an ***estimate*** for services in advance of your appointment/s to ensure you opportunity to plan in advance for your dental care. We believe whether you privately pay or have dental insurance to assist you, everyone deserves the care they need and want.

_____
Initials

PAYMENT OPTIONS
For your convenience we accept most credit cards, checks and provide payment options to help you receive the quality care you need to enjoy a healthy and confident smile.

Please note: A $25.00 NFS fee will be charged for returned checks. Should you desire a monthly payment plan we invite you to complete a Care Credit application. There are no application fees or a down payment and the loan can be interest free.

_____
Initials

PAST DUE BALANCES
A balance is consider "Past Due" on any account that has a balance over 90-days; with no payment arrangement on file. Please be advised we will attempt to contact you, however if our attempts become unsuccessful you will be sent to *collection* without further notice.

_____
Initials

CANCELLATIONS
If you are unable to keep an appointment that has been reserved for you we request you provide us with a 2 business day advance courtesy notice. Early notification ensures that we can offer you a more convenient appointment and allows us sufficient time to accommodate the needs of another patient. We realize that emergencies do occur and we will be flexible under those circumstances.

_____
Initials

INFORMATION CHANGES
To ensure you records are current please notify us of any changes related to medical history, telephone number/s, address, employer or insurance information as they occur.

_____
Initials

My signature indicates that I understand that policies as outlined and any questions I have with regards to office policies have been answered.

Signature of Responsible Party or Patient Date

Signature of Staff Member or Doctor Date

Patient Testimonial Authorization:

We would be honored to share your written testimonial about our practice with other patients and possibly use the testimonial for marketing and advertising purposes, as well as any photo's taken in our office of yourself and/or your child or the child for whom you have legal guardianship. In order to do so, we would like to obtain your authorization.

I hereby give my consent for Dr. Chan to use the written testimonial and/or photo's of_____ (patient's name) for marketing purposes. I understand that the testimonial and/or photo's will be shared both internally among patients of Dr. Chan's practice as well as externally in print materials and on the internet. I do not expect compensation, financial or otherwise, for the use of the testimonial.

Please Initial:

____ I consent to the use of my testimonial and/or photo's for marketing and advertising purposes.

____ I consent to the use of my testimonial and/or photo's for internal use only with patients of Dr. Chan's practice.

I understand that the information disclosed under this authorization may be subject to redisclosure and no longer protected by the federal privacy regulations. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment, or eligibility for benefits. Finally, I understand that I may revoke this authorization in writing at any time by sending a letter to my dental care provider stating my revocation and the effective date, except to the extent that action has been taken in reliance on this authorization. Unless revoked by me, this authorization expires 10 years from the date I sign below.

_____ _____

Patient's or Legal Guardian's/Representative's signature Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*****You May Refuse to Sign This Acknowledgement*

I, _____, have received a copy of This office's 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 Practices, but acknowledgement could not be obtained because:

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

_____
_____
_____

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