ADA Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)

☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization

☐ EPSDT/Title XIX

2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

OTHER COVERAGE

4. Other Dental or Medical Coverage? ☐ No (Skip 5-11) ☐ Yes (Complete 5-11)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY) 7. Gender ☐ M ☐ F 8. Policyholder/Subscriber ID (SSN or ID#)

9. Plan/Group Number 10. Patient's Relationship to Person Named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/CCYY) 14. Gender ☐ M ☐ F 15. Policyholder/Subscriber ID (SSN or ID#)

16. Plan/Group Number 17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other

19. Student Status ☐ FTS ☐ PTS

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY) 22. Gender ☐ M ☐ F 23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

MISSING TEETH INFORMATION

34. (Place an 'X' on each missing tooth)

Permanent																Primary									
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K

32. Other Fee(s)

33. Total Fee

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X

Patient/Guardian signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X

Subscriber signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment ☐ Provider's Office ☐ Hospital ☐ ECF ☐ Other

39. Number of Enclosures (00 to 99) Radiograph(s) Oral Image(s) Model(s)

40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining

43. Replacement of Prosthesis? ☐ No ☐ Yes (Complete 44)

44. Date Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY) 47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)

48. Name, Address, City, State, Zip Code

49. NPI 50. License Number 51. SSN or TIN

52. Phone Number ( ) – 52A. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X

Signed (Treating Dentist) Date

54. NPI 55. License Number

56. Address, City, State, Zip Code 56A. Provider Specialty Code

57. Phone Number ( ) – 58. Additional Provider ID

©2006 American Dental Association

Printed on Recycled Paper

J400 (Same as ADA Dental Claim Form – J401, J402, J403, J404)

American Dental Association
www.ada.org

Comprehensive completion instructions for the ADA Dental Claim Form are found in Section 4 of the ADA Publication titled *CDT-2007/2008*. Five relevant extracts from that section follow:

General Instructions

A. The form is designed so that the name and address (Item 3) of the third-party payer receiving the claim (insurance company/dental benefit plan) is visible in a standard #10 window envelope. Please fold the form using the 'tick-marks' printed in the margin.

B. In the upper-right of the form, a blank space is provided for the convenience of the payer or insurance company, to allow the assignment of a claim or control number.

C. All Items in the form must be completed unless it is noted on the form or in the following instructions that completion is not required.

D. When a name and address field is required, the full name of an individual or a full business name, address and zip code must be entered.

E. All dates must include the four-digit year.

F. If the number of procedures reported exceeds the number of lines available on one claim form, the remaining procedures must be listed on a separate, fully completed claim form.

Coordination of Benefits (COB)

When a claim is being submitted to the secondary payer, complete the form in its entirety and attach the primary payer's Explanation of Benefits (EOB) showing the amount paid by the primary payer. You may indicate the amount the primary carrier paid in the "Remarks" field (Item # 35).

National Provider Identifier (NPI)

49 and 54 NPI (National Provider Identifier): This is an identifier assigned by the Federal government to all providers considered to be HIPAA covered entities. Dentists who are not covered entities may elect to obtain an NPI at their discretion, or may be enumerated if required by a participating provider agreement with a third-party payer or applicable state law/regulation. An NPI is unique to an individual dentist (Type 1 NPI) or dental entity (Type 2 NPI), and has no intrinsic meaning. Additional information on NPI and enumeration can be obtained from the ADA's Web Site: **www.ada.org/goto/npi**

Additional Provider Identifier

52A and 58 Additional Provider ID: This is an identifier assigned to the billing dentist or dental entity other than a Social Security Number (SSN) or Tax Identification Number (TIN). It is not the provider's NPI. The additional identifier is sometimes referred to as a Legacy Identifier (LID). LIDs may not be unique as they are assigned by different entities (e.g., third-party payer; Federal government). Some Legacy IDs have an intrinsic meaning.

Provider Specialty Codes

56A Provider Specialty Code: Enter the code that indicates the type of dental professional who delivered the treatment. Available codes describing treating dentists are listed below. The general code listed as 'Dentist' may be used instead of any other dental practitioner code.

Category / Description Code	Code
Dentist A dentist is a person qualified by a doctorate in dental surgery (D.D.S) or dental medicine (D.M.D.) licensed by the state to practice dentistry, and practicing within the scope of that license.	122300000X
General Practice	1223G0001X
Dental Specialty (see following list)	Various
Dental Public Health	1223D0001X
Endodontics	1223E0200X
Orthodontics	1223X0400X
Pediatric Dentistry	1223P0221X
Periodontics	1223P0300X
Prosthodontics	1223P0700X
Oral & Maxillofacial Pathology	1223P0106X
Oral & Maxillofacial Radiology	1223D0008X
Oral & Maxillofacial Surgery	1223S0112X

Dental provider taxonomy codes listed above are a subset of the full code set that is posted at:
www.wpc-edi.com/codes/taxonomy

Should there be any updates to ADA Dental Claim Form completion instructions, the updates will be posted on the ADA's web site at:
www.ada.org/goto/dentalcode

FINANCIAL POLICY

The following is a statement of Our Financial Policy, which we ask that you read and sign prior to treatment. All patients must complete our Information and Insurance forms before seeing the doctor.

WE ACCEPT CASH, CHECKS, DEBIT, OR VISA, MASTERCARD

Regarding Insurance

The balance is your responsibility whether your insurance pays or not. We cannot bill your insurance company unless you give us your complete insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Please understand there are many different insurance plans. As a courtesy to you our staff spends a great deal of time getting information and benefits. We do the best we can with the information the insurance gives us. This is not a guarantee of payment. Payment is determined at the time the claim is received by the insurance company. If your insurance company has not paid your account in full with in 30 days, the balance will be automatically your responsibility. Please be aware that some and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary by your insurance.

All co-pays and deductibles are due at the time of service. In the event that your insurance coverage changes our office must be notified at least 2 business days prior to the appointment to insure proper verification. If for some reason we are not notified in advance you will be responsible for 100% of the charges accrued.

Usual and Customary

Our practice is committed to providing the best treatment for our patients and we charge our usual and customary fees to all our patients. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. Your policy may base its allowances on a fixed fee schedule, which may or may not coincide with our office is far above those guidelines.

The adult accompanying a minor and the parents (or guardians) are responsible for full payment.

Missed Appointments

A notice of 24 hours in advance is required for unkept appointment. A dental charge could be incurred if no notice is given in advance. Please help us serve you better by keeping scheduled appointments.

______________________________ ____________________

Parent or Guardian Date

RALPH FLORES, D.D.S., INC

Dentista para ninos

5500 Walzem Road
San Antonio, Texas 78218
(210)657-4641

INFORMACION DE ESTA OFICINA
(FAVOR DE LEER)

Dr. Flores y su ayudantes Le dan la bienvenida a uno de las mejores oficinas dental para ninos en San Antonio. La salud de su nino/nina y bien estar es muy importante para nosotros.

Dr. Flores graduados de la Universidad Dental de Texas aquí en San Antonio en 1976. En 1993 esta escuela a sido nombrada #1 en el estado. Su entrenamiento en esta especialidad fue en el Hospital de ninos de Houston, Tx.

Un Dentista pediatrico es un especialista q'a recibido dos anos adicionales de entrenamiento. El es un experto para tratar con el crecimiento emocional y fisico de su nino/nina. Nuestra meta debera asegurar que su nino reciba usar dental excelente de cuidado las mayoria de las corrientes.

El Dr. Flores es un miembro de La Asociacion Dental Americana y el Academia Pediatrica Americana de Dentistas, a servido como presidente de la asociacion Dental de Ninos en Texas. Alhora mismo sostiene una posicion como profesor en La Clinica Pediatric Dispensario en el Hospital de Santa Rosa.

Debido la demanda para el cuidado de ninos, Dr. Flores en tiempo emplea pediatric los socios dental para ayudarle.

Ultimos cancelaciones diminutos o las citas perdidas pueden afetar las citas futuras y/o pueden resultar un $25.00 re-honorario de cita.

Los padres y/o Guardianes son responsable de nino en el area del recepcion. ¡Los padres son preguntados NO SALIR mientras sus ninos son tratados!

He leido y he entendido que las normas de esta oficina un da el consentimiento a Dr. Flores y su personal para examinar a mi nino que usa RADIOGRAFIA cuando necesario y para proporcionar el tratamiento que ha sido explicado completamente.

Examenes Periodicos Preventivo-Prevencion es la clave para clientes para dientes sanos y una bonita sonrisa. Nosotros recomendamos dos examenes al ano para su nino/nina. En esta visita los dientes de su nino/nina seran limpiados y se les dara un tratamiento de fluoride. Dr. Flores entonces evaluara para el decaimiento posible, la enfermedad de goma, dientes amontonados o cualquier otros problemas. Esto es una inversion saba para su nino.

Esterlizacion-Esta oficina reune y exede todo gobierno los estandares requeridos para el sterilzation. Ultizamos el ultimo en la tecnica y el equipo. El uso de mascaras y guantes es rutinario. Los articulos para tirar se usan donde posible y todos los otros instrumentos/el equipo, inclusive handpieces (en otras palabras, los taladros) son sterilized despues cada uso.

Horas de Oficina-Nuestro horario regular es de Lunes a Viernes 8:00-5:00. Para emergencias se puede comunicar con el Dr. Flores al 650-7850.

La importancia de su cita -Cada cita es especialmente reservado para usted y su nino/nina. Las citas perdidas o tardes afecta todos. Entendemos tambien los horarios de trabajo y la imortancia de asistencia de escuela; sin embargo, es imposible acomodar a todas nuestros pacientes despues de escuela. Proporcionaremos una excusa de escuela y pediremos que usted coopere por favor con nuestro en planificar. Gracias.

El pago, el seguro y la colección-Como una cortesia beneficio para usted estaremos encantados de llenar papeles de aceguransa. Entienda por favor que eso hay muchos planes diferentes del seguro muchos pagos del afecto de factores. Podemos solo le da una estimacion. Aceptamos tarjetas de credito y cheques personales limpiados por TeleCheck. Los cargos para cheques vueltos el pasado asi como tambien impagado de equilibrios 30 dias son para su responsabilidad.

____________________________ Fecha____________

Pariente/Guardia

Ralph Flores, D.D.S.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, out legal duties, and your rights concerning you health information. We must follow the privacy practices that are described on this Notice while it is in affect. This Notice takes affect 04/15/03 and will remain in until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or, for additional copies of the Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOUSERS OF HEALTH INFORMATION

We use and disclose health information about you for treatment operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide for you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it is in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, or your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health- Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to you health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of armed forces personnel under certain circumstances. We may disclose to authorize federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: you have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for the expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you$0.**25** for each page, $**10.00** per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing you health information in that format. If you prefer, we will prepare a summary or an explanation of your health for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our structure.)

Disclosure Accounting: You have the right to receive a list of instance in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14.2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding, but if we do, we will abide by our agreement (except in an emergency).

Alternative communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our web site or by electronic mail (email), you are entitled to receive this Notice in written form.

QUESTIONS AN COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S Department of Health and Human Resources. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Elsa Becerra.

Telephone: 210-657-4641. Fax: 210-655-4012

E-mail: elsa@floresdds.com

Address: 5500 Walzem Rd.

San Antonio, TX 78218

RALPH FLORES, D.D.S.
5500 Walzem
San Antonio, Texas 78218
(210) 657-4641

OFFICE INFORMATION

PERIODIC PREVENTION EXAMS- Prevention is the key to healthy teeth and a pretty smile. We recommend biannual exams. Depending on the age of the patient, at this appointment your teeth will be cleaned and given a fluoride treatment. During your visit you will be evaluated for possible decay, gum disease, crowded teeth and any other problems. This is a wise investment for yourself and your child.

STERILIZATION- This office meets or exceeds all government required standards for sterilization. We utilize the latest in techniques and equipment. The use of masks and gloves is routine. Disposable items are used whenever possible and all other instruments/equipment, including hand pieces (drills) are sterilized after each use.

OFFICE HOURS- Our regular office hours are Monday through Friday, 8:00 – 5:00. For dental emergencies you may reach Dr Flores at 710-3990, Dr. Amos at 535-9841.

PARENTAL SEPARATION- It is our experience that children respond better to the dentist when parents are not in the same room. We can assure you that your child is not left alone and is well cared for. Exceptions to this policy are for the emotionally, mentally or physically handicapped children. Parents are asked not to leave the office while your child is being treated. Thank you for your cooperation.

IMPORTANCE OF APPOINTMENTS- Each appointment is especially reserved for yourself and your child. Missed or late appointments affect everybody. A re-appointment fee may be assessed. We also understand working schedules and the importance of school attendance; however it is impossible to accommodate all our patients after school. We will provide a school excuse and ask that you please cooperate with our scheduling. Thank you.

PAYMENT, INSURANCE AND COLLECTION- As a courtesy we will be happy to submit completed dental services to your insurance company for you. Please understand that there are many different insurance plans and many factors affect payment. We can only give you an educated estimate as to what your portion will be. Be aware that this is only an estimate. We accept major credit cards and personal checks cleared through TeleCheck. Charges for returned checks as well as unpaid balances past 30 days are your responsibility.

DENTAL RECORDS- Original records including x-rays belong to the dentist. We will send copies of records upon request to another dentist as a professional courtesy (no charge). Otherwise there will be a duplication fee of $25.00.

NO SEDETION- Although oral sedation (tranquilizers) or general anesthesia (completely asleep) are safe ways of treating children there are still some risks involved. Dr. Flores does not use either of these methods, and instead depends on his years of experience and well trained assistants. Often this is all that is necessary. If however it is felt that your child cannot cope without sedation you will be referred to a Pediatric Dentist who does practice these methods.

I have read and understand the policies of this office.

____________________________________ ________________________

Parent or Guardian Date

(PLEASE PRINT)

Patient Information

Date ______

SS/HIC/Patient ID # ______

Patient Name ______
Last Name

______
First Name Middle Initial

Address ______

E-mail ______

City ______

State ______ Zip ______

Sex ☐ M ☐ F Age ______

Birthdate ______

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for ____ years

Patient Employer/School ______

Occupation ______

Employer/School Address ______

______

Employer/School Phone (____) ______

Spouse's Name ______

Birthdate ______

SS# ______

Spouse's Employer ______

Whom may we thank for referring you? ______

Dental Insurance

Who is responsible for this account? ______

Relationship to Patient ______

Insurance Co. ______

Group # ______

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name ______

Birthdate ______ SS# ______

Relationship to Patient ______

Insurance Co. ______

Group # ______

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with ______ and assign directly to
Name of Insurance Company(ies)

Dr. ______ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

______
Signature of Patient, Parent, Guardian or Personal Representative

______
Please print name of Patient, Parent, Guardian or Personal Representative

______ ______
Date Relationship to Patient

Phone Numbers

Home (____) ______ Work (____) ______ Ext ____ Cell Phone (____) ______

Spouse's Work (____) ______ Best time and place to reach you ______

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name ______ Relationship ______

Home Phone (____) ______ Work Phone (____) ______

Dental History

Reason for today's visit ______

______

Former Dentist ______

City/State ______

Date of last dental visit ______

Date of last dental X-rays ______

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad breath ☐ Yes ☐ No
Bleeding gums ☐ Yes ☐ No
Blisters on lips or mouth ☐ Yes ☐ No
Burning sensation on tongue ☐ Yes ☐ No
Chew on one side of mouth ☐ Yes ☐ No
Cigarette, pipe, or cigar smoking ☐ Yes ☐ No
Clicking or popping jaw ☐ Yes ☐ No
Dry mouth ☐ Yes ☐ No
Fingernail biting ☐ Yes ☐ No
Food collection between the teeth ☐ Yes ☐ No
Foreign objects ☐ Yes ☐ No
Grinding teeth ☐ Yes ☐ No
Gums swollen or tender ☐ Yes ☐ No
Jaw pain or tiredness ☐ Yes ☐ No
Lip or cheek biting ☐ Yes ☐ No
Loose teeth or broken fillings ☐ Yes ☐ No
Mouth breathing ☐ Yes ☐ No
Mouth pain, brushing ☐ Yes ☐ No
Orthodontic treatment ☐ Yes ☐ No
Pain around ear ☐ Yes ☐ No
Periodontal treatment ☐ Yes ☐ No
Sensitivity to cold ☐ Yes ☐ No
Sensitivity to heat ☐ Yes ☐ No
Sensitivity to sweets ☐ Yes ☐ No
Sensitivity when biting ☐ Yes ☐ No
Sores or growths in your mouth ☐ Yes ☐ No

How often do you floss? ______

How often do you brush? ______

Dental Registration and History

#20605 – © 2004 Medical Arts Press® 1-800-328-2179

Health History

Physician's Name ______________________ Date of last visit ______________

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Condition	Yes	No
AIDS/HIV	☐ Yes	☐ No
Anemia	☐ Yes	☐ No
Arthritis, Rheumatism	☐ Yes	☐ No
Artificial Heart Valves	☐ Yes	☐ No
Artificial Joints	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Back Problems	☐ Yes	☐ No
Bleeding abnormally, with extractions or surgery	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No
Circulatory Problems	☐ Yes	☐ No
Congenital Heart Lesions	☐ Yes	☐ No
Cortisone Treatments	☐ Yes	☐ No
Cough, persistent or bloody	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No
Fainting or dizziness	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No
Headaches	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No
Heart Problems	☐ Yes	☐ No
Hepatitis Type ______	☐ Yes	☐ No
Herpes	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No
Jaundice	☐ Yes	☐ No
Jaw Pain	☐ Yes	☐ No
Kidney Disease	☐ Yes	☐ No
Liver Disease	☐ Yes	☐ No
Low Blood Pressure	☐ Yes	☐ No
Mitral Valve Prolapse	☐ Yes	☐ No
Nervous Problems	☐ Yes	☐ No
Pacemaker	☐ Yes	☐ No
Psychiatric Care	☐ Yes	☐ No
Radiation Treatment	☐ Yes	☐ No
Respiratory Disease	☐ Yes	☐ No
Rheumatic Fever	☐ Yes	☐ No
Scarlet Fever	☐ Yes	☐ No
Shortness of Breath	☐ Yes	☐ No
Sinus Trouble	☐ Yes	☐ No
Skin Rash	☐ Yes	☐ No
Special Diet	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Swollen Feet or Ankles	☐ Yes	☐ No
Swollen Neck Glands	☐ Yes	☐ No
Thyroid Problems	☐ Yes	☐ No
Tonsillitis	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No
Tumor or growth on head or neck	☐ Yes	☐ No
Ulcer	☐ Yes	☐ No
Venereal Disease	☐ Yes	☐ No
Weight Loss, unexplained	☐ Yes	☐ No

Do you wear contact lenses? ☐ Yes ☐ No

Women:

Are you pregnant? ☐ Yes ☐ No Due date ______________ Are you nursing? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No

Medications

List any medications you are currently taking and the correlating diagnosis:

____

____

Pharmacy Name ______________________

Phone (_____) ______________________

Allergies

☐ Aspirin
☐ Barbiturates (Sleeping pills)
☐ Codeine
☐ Iodine
☐ Latex
☐ Local Anesthetic
☐ Penicillin
☐ Sulfa
☐ Other ______________

Updates (To be filled in at future appointments)

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? ______________________

Are you taking any new medications? __________ If so, what? ______________

Patient's Signature ______________________ Date ______________

Doctor's Signature ______________________ Date ______________

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? ______________________

Are you taking any new medications? __________ If so, what? ______________

Patient's Signature ______________________ Date ______________

Doctor's Signature ______________________ Date ______________