New Health History

Patient Information

Patient Name:

First Name | Middle Name | Last Name

Preferred Name:

Gender

- Male
- Female

Gender

- Married
- Single
- Child
- Other:

Social Security #:

Email:

example@example.com

D.O.B:

Date

Cell Phone #:

Please enter a valid phone number.

Home Phone #:

Please enter a valid phone number.

Address:

Street Address

City

State / Province

Postal / Zip Code

Health Information

Date of last Dental visit:

Date

Reason for today's visit:

Date

Describe the nature of any health conditions you are currently being treated for:

Conditions	Date of Onset	Physician/ Physician's Phone #	Medicines being taken

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List all other medications you are currently taking: (Please provide a detailed list of ALL medications)

Describe any other conditions you have been treated for in the past five years.

Condition	Date Treated	Physician	Physician's Phone #

Condition	Date Treated	Physician	Physician's Phone #

Condition	Date Treated	Physician	Physician's Phone #

Condition	Date Treated	Physician	Physician's Phone #

Condition	Date Treated	Physician	Physician's Phone #

Do you have any health problems that need further clarification?

- ◯ Yes
- ◯ No

Are you currently pregnant or think you may be pregnant?

- ◯ Yes
- ◯ No

Are you currently nursing?

- ◯ Yes
- ◯ No

Do you smoke?

- ◯ Yes
- ◯ No

Have you ever had any of the following? Please check those that apply, if not already noted above:

- [ ] AIDS/HIV
- [ ] COPD or Emphysema
- [ ] Joint Replacement
- [ ] Anemia
- [ ] Osteoporosis Medication
- [ ] Stomach Problems or Ulcers
- [ ] Liver Disease
- [ ] Heart Attack
- [ ] Cancer
- [ ] Prosthetic Heart Valve
- [ ] Penicillin Allergy
- [ ] Radiation Treatment
- [ ] Other Medication cannot take
- [ ] Excessive Bleeding
- [ ] Allergies
- [ ] Sinus Problem
- [ ] Chemotherapy
- [ ] Kidney Disease
- [ ] Asthma
- [ ] Stroke
- [ ] Mental or Nervous Disorder
- [ ] Heart Disease
- [ ] Diabetes
- [ ] Dizziness
- [ ] High Blood Pressure
- [ ] Fainting
- [ ] Epilepsy
- [ ] Chest Pain
- [ ] Blood Thinner
- [ ] Thyroid Problem
- [ ] Benign Tumors
- [ ] Tuberculosis
- [ ] Pacemaker
- [ ] Head Injuries
- [ ] Hepatitis

Have you ever had any complications following dental treatment or dental injections?

- ( ) Yes
- ( ) No

Are you interested in Sedation?

- ( ) Yes
- ( ) No

Is there anything you want to change about your smile?

To the best of my knowledge, all the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform my doctor at the next appointment without fail.

Signature of Patient, Parent, or Guardian

Date:

Date

Referral Information

Whom may we thank for referring you to our practice?

- [ ] Internet
- [ ] Newspaper
- [ ] Work
- [ ] Another patient, relative
- [ ] Other:
- [ ] Yellow Pages
- [ ] Flyer
- [ ] Another patient, friend

Name of person or office referring you to our practice:

Spouse or Responsible Party Information

The following is for:

- ( ) The patient's spouse
- ( ) The person responsible for patient

Name:

Gender

- ( ) Male
- ( ) Female

- ( ) Married
- ( ) Single
- ( ) Child
- ( ) Other:

Social Security # :

Birth Date:

Date

Phone: (Home):

Please enter a valid phone number.

Phone: (Work):

Please enter a valid phone number.

Phone: (Cell):

Please enter a valid phone number.

Address:

Street Address

City

State / Province

Postal / Zip Code

In case of Emergency, call:

(Close Relative not living at your home address)

Phone (Work):

Please enter a valid phone number.

Phone (Cell):

Please enter a valid phone number.

Employment Information

The following is for:

- ◯ The Patient
- ◯ The person responsible for payment

Employer Name:

Occupation:

Address:

Street Address

City

State / Province

Postal / Zip Code

Insurance Information

Primary

Name of Insured:

First Name | Middle Name | Last Name

Is insured a patient?

- Yes
- No

Insured's Birth Date:

Date

ID#:

Group #:

Insured's Employer Name:

Patient's relationship to insured:

- Self
- Spouse
- Child
- Other:

Insurance Plan Name and Address:

Secondary

Name of Insured:

First Name | Middle Name | Last Name

Is insured a patient?

- Yes
- No

Insured's Birth Date:

Date

ID#:

Group #:

Insured's Employer Name:

Patient's relationship to insured:

- ◯ Self
- ◯ Spouse
- ◯ Child
- ◯ Other:

Insurance Plan Name and Address:

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time of services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment if all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I grant permission to Chattanooga Dental Arts for use of my photographs for educational and commercial purposes.

A service charge of 1.5% per month (18% per annum) or $5.00, which ever is greater, will be charged on the unpaid balance of all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within (5) days billing if credit shall be extended. I further agree that a waiver if any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all collections and reasonable attorney fees if suit be instituted hereunder.

I grant permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

Signature of Patient, Parent, or Guardian

Date:

Date

Relationship to Patient:

Signature of Guarantor of payment/ responsible party:

Date:

Date

Relationship to Patient: