PETER M. HECKLER, D.D.S., INC.
NANCY MORROW, D.D.S.

FAMILY & COSMETIC DENTISTRY

PERSONAL INFORMATION

Today's Date___________________

Name ____

What do you wish to be called ___________________________

Referred by ____

Email address ____

Address____

City/State/Zip ____

Home Phone _________________ Business/Cell ___________________

Preferred method of correspondence ○ text ○ email ○ cell ○ home

○ Male ○ Female ○ Single ○ Married

Date of Birth________________________

SS #______________________

Occupation____

Emergency Contact __________________ Relationship _____________

Home Phone __________________ Cell Phone ___________________

If you are completing this form for another person what is your relationship to that person____

RESPONSIBLE PARTY

Who is responsible for the account?

Name ____

Birth date _________________ SS# ____________________________

Relationship to patient ____________________________________

Address ____

City/State/Zip ____

Employer ____

Employer Address____

Work Phone ________________ Home Phone ______________________

DENTAL INSURANCE INFORMATION

Name of Insured ____

Relationship to patient ____

Insured's birth date _____________SS# ___________________________

Employer ________________________Date Employed ______________

Employer Address____

Insurance Company ____

Group # ____

Ins. Co. Address ____

ADDITIONAL INSURANCE

Name of Insured ____

Relationship to patient ____

Insured's birth date _____________SS# ___________________________

Employer ____

Employer Address____

Insurance Company ____

Group # ____

Ins. Co. Address ____

FINANCIAL ARRANGEMENTS

For your convenience, we offer the following methods of payment. Please check the option which you prefer.

Payment in full at each appointment.

_____Cash _____ Personal Check _____Credit Card _____Visa_____ MC _____ AMX

Late charges: If I do not pay the entire new balance within 90 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month. I realize that failure to keep this account current may result in you being unable to provide additional services. In the case of default on payment of this account, I agree to collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

AUTHORIZATION & RELEASE

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or other health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made.

X ____

Signature of patient or parent if minor Date

PETER M. HECKLER, D.D.S., INC.
NANCY A. MORROW, D.D.S.

FAMILY & COSMETIC DENTISTRY

Confidential Health History

Patient Name: ______________________________ Date of Birth: ____________________

I. CIRCLE APPROPRIATE ANSWER (Leave blank if you do not understand the question)

1. Yes / No Is your general health good?
   If NO, explain: ______________________________
2. Yes / No Has there been a change in your health with the last year?
   If YES, explain: ______________________________
3. Yes / No Have you gone to the hospital or emergency room or had a serious illness in the last three years?
   If YES, explain: ______________________________
4. Yes / No Are you being treated by a physician now? If YES, explain: ______________________________
   Date of last medical exam?____________ Reason for exam: ____________________
5. Yes / No Have you had problems with prior dental treatment?
   If YES, explain: ______________________________
   Date of last dental exam:____________ Name of last treating dentist: ____________________
6 Yes / No Are you in pain now?
   If YES, explain: ______________________________

II. HAVE YOU EXPERIENCED ANY OF THE FOLLOWING IN THE LAST FIVE YEARS? (Please circle Yes or No for each)

Yes / No	Chest pain (angina)	Yes / No	Blood in stools	Yes / No	Frequent vomiting
Yes / No	Fainting spells	Yes / No	Diarrhea or constipation	Yes / No	Jaundice
Yes / No	Recent significant weight loss	Yes / No	Frequent urination	Yes / No	Dry mouth
Yes / No	Fever	Yes / No	Difficulty urinating	Yes / No	Excessive thirst
Yes / No	Night sweats	Yes / No	Ringing in ears	Yes / No	Difficulty swallowing
Yes / No	Persistent cough	Yes / No	Headaches	Yes / No	Swollen ankles
Yes / No	Coughing up blood	Yes / No	Dizziness	Yes / No	Joint pain or stiffness
Yes / No	Bleeding problems	Yes / No	Blurred vision	Yes / No	Shortness of breath
Yes / No	Blood in urine	Yes / No	Bruise easily	Yes / No	Sinus problems

Other: ______________________________

III. HAVE YOU EVER HAD OR DO YOU HAVE ANY OF THE FOLLOWING? (Please circle Yes or No for each)

Yes / No	Heart disease	Yes / No	AIDS/HIV	Yes / No	Psychiatric care
Yes / No	Family history of heart disease	Yes / No	Surgeries	Yes / No	Osteoporosis
Yes / No	Heart attack	Yes / No	Hospitalization	Yes / No	Thyroid disease
Yes / No	Artificial joint	Yes / No	Diabetes	Yes / No	Asthma
Yes / No	Stomach problems or ulcers	Yes / No	Family history of diabetes	Yes / No	Hepatitis
Yes / No	Heart defects	Yes / No	Tumors or cancer	Yes / No	Sexual transmitted disease
Yes / No	Heart murmurs	Yes / No	Chemotherapy	Yes / No	Herpes
Yes / No	Rheumatic fever	Yes / No	Radiation	Yes / No	Canker or cold sores
Yes / No	Skin disease	Yes / No	Arthritis, rheumatism	Yes / No	Anemia
Yes / No	Hardening of arteries	Yes / No	Emphysema or other lung disease	Yes / No	Liver disease
Yes / No	High blood pressure	Yes / No	Kidney or bladder disease	Yes / No	Eye disease
Yes / No	Seizures	Yes / No	Stroke	Yes / No	Transplants
Yes / No	Cosmetic surgery	Yes / No	Eating disorders	Yes / No	Tuberculosis

Other: ______________________________

IV. ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING?

(Please circle Yes or No for each)

Yes / No	Aspirin	Yes / No	Valium or other sedatives	Yes / No	Codeine or other narcotics
Yes / No	Penicillin or other antibiotics	Yes / No	Latex	Yes / No	Food
Yes / No	Nitrous oxide	Yes / No	Local anesthetic	Yes / No	Metal

Others: ____

V. ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE LAST THREE MONTHS?

(Please circle Yes or No for each)

Yes / No	Recreational drugs	Yes / No	Tobacco in any form	Yes / No	Antibiotics
Yes / No	Over-the-counter medicines	Yes / No	Alcohol	Yes / No	Supplements
Yes / No	Weight loss medications	Yes / No	Bisphosphonate (Fosamax)	Yes / No	Aspirin
Yes / No	Anti-Depressants	Yes / No	Herbal Supplements		

Please list all prescription medications: ____

VI. WOMEN ONLY (Please circle Yes or No for each)

Yes / No Are you or could you be pregnant? If YES, what month? ______________________

Yes / No Are you nursing?

Yes / No Are you taking birth control pills?

VII. ALL PATIENTS (Please circle Yes or No for each)

Yes / No Do you have or have you had any other diseases or medical problems NOT listed on this form?
If YES, please explain: ____

____

Yes / No Have you ever been pre-medicated for dental treatment? If YES, why: ______________________

Yes / No Have you ever taken Fen-Phen? If YES, when: ______________________

Yes / No **Is there any issue or condition that you would like to discuss with the dentist in private?**

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically compromised situation, medical consultation may be needed prior to commencement of dental treatment.

I authorize the dentist to contact my physician.

Patient's Signature: ______________________ Date: ______________________

Physician's Name: ______________________ Phone Number: ______________________

Whom would you like us to contact in case of an emergency?

Name: ______________ **Relationship:** ______________ **Phone Number:** ______________

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

______________________ ____________ ______________________ ____________

Signature of Patient (Parent or Guardian) Date Signature of Dentist Date

PETER M. HECKLER, D.D.S., INC.
NANCY A. MORROW, D.D.S.

FAMILY & COSMETIC DENTISTRY

DENTAL HISTORY FORM

PATIENT NAME ______________________________ DATE OF BIRTH ______________________

DATE OF LAST DENTAL VISIT ______________________ REASON FOR VISIT ______________________

DATE OF LAST X-RAYS ____

FORMER DENTIST ______________________________ PHONE ______________________

ADDRESS ______________________________ CITY ______________ STATE __________

CIRCLE APPROPRIATE ANSWER (Leave blank if you do not understand the questions)

Are you currently experiencing dental pain or discomfort? Yes/ No

If YES, explain: ____

Do your gums bleed? Yes/No

If YES, explain: ____

Are any of your teeth loose? Yes/No

If YES, explain: ____

Have you ever had dental implants placed? Yes/No

If YES, where/when: ____

Have you ever been told you have gum disease? Yes/No

Are your teeth sensitive to hot, cold, sweets or pressure? Yes/No

If YES, explain: ____

Have you ever had any clicking, popping or discomfort in the jaw? Yes/No

If YES, explain: ____

Do you brux or grind your teeth? Yes/No Do you wear an occlusal guard? Yes/No

If YES, explain: ____

Have you ever had orthodontic treatment (braces) before? Yes/No

If YES, where/when: ____

Do you have dry mouth? Yes/No

If YES, explain: ____

Does food or floss catch between your teeth? Yes/No

If YES, explain: ____

Have you had any problems or an upsetting dental experience associated with previous dental care? Yes/No

If YES, explain: ____

Are you fearful of dentistry or have anxiety associated with dental treatment? Yes/No

If YES/explain: ____

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 dental 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.

____

Signature of Patient (Parent or Guardian) **Date**

____

Signature of Dentist **Date**

PEDIATRIC HEALTH HISTORY

Child's Physician ______________________________ Phone ______________________

	Yes	No
Is the child taking any prescription and/or over-the-counter medications or vitamin supplements at this time?	☐	☐
If yes, please list ______________________________		
Is the child allergic to any medications, i.e., penicillin, antibiotics, or other drugs?	☐	☐
If yes, please explain ______________________________		
Is the child allergic to anything else such as certain drugs? If yes, please explain: ______________________	☐	☐
How would you describe the child's eating habits? ______________________________		
Has the child ever had a serious illness? If yes, when __________ please describe ______________________	☐	☐
Has the child ever been hospitalized?	☐	☐
Has the child ever received general anesthesia?	☐	☐
Does the child have any speech difficulties?	☐	☐
Has the child ever had a blood transfusion?	☐	☐
Is the child physically, mentally, or emotionally impaired?	☐	☐
Does the child experience excessive bleeding when cut?	☐	☐
Is this the chid's first visit to a dentist? If not the first visit, what was the date of the last dental visit? Date: ______________	☐	☐
Has the child had any problem with dental treatment in the past?	☐	☐
Has the child ever had dental radiographs (x-rays) exposed?	☐	☐
Has the child ever suffered any injuries to the mouth, head or teeth?	☐	☐
Has the child had any problems with the eruption or shedding of teeth?	☐	☐
Has the child had any orthodontic treatment?	☐	☐
What type of water does your child drink? _____ City water _____ Well water _____ Bottled water _____ Filtered water		
Does the child take fluoride supplements?	☐	☐
Is fluoride toothpaste used?	☐	☐
How many times are the child's teeth brushed per day? __________ When are the teeth brushed? ______________		
Does the child suck his/her thumb, fingers or pacifier?	☐	☐
Does child participate in active recreational activities?	☐	☐

Has the child had any history of, or conditions related to, any of the following:

- O Anemia
- O Arthritis
- O Asthma
- O Bladder
- O Bleeding Disorders
- O Bone/Joints
- O Cancer
- O Cerebral Palsy
- O Chicken Pox
- O Chronic Sinusitis
- O Diabetes
- O Earaches
- O Epilepsy
- O Fainting
- O Growth Problems
- O Hearing
- O Heart
- O Hepatitis
- O HIV + / AIDS
- O Immunizations
- O Kidney
- O Latex Allergy
- O Liver
- O Measles
- O Mononucleosis
- O Mumps
- O Pregnancy (Teens)
- O Rheumatic Fever
- O Seizures
- O Sickle Cell
- O Thyroid
- O Tobacco / Drug Use
- O Tuberculosis
- O Venereal Disease
- O Others please list ______________________

____

____

____

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff on the next appointment without fail.

X______________________________ Date ______________________

PATIENT SIGNATURE (PARENT OR GUARDIAN)

Reviewed by Doctor ______________________________ Date ______________ BP ______________

History Review and Significant Findings ______________________________

MEDICAL UPDATES

I have reviewed my Health History and confirm that it accurately states past and present conditions.

DATE	PATIENT SIGNATURE	CHANGES TO HEALTH HISTORY	DENTIST INITIALS

(AS 10/2014)