

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 _____

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

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 _____

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

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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?.....	<input type="checkbox"/>	<input type="checkbox"/>
If yes, please list _____		
Is the child allergic to any medications, i.e., penicillin, antibiotics, or other drugs?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, please explain _____		
Is the child allergic to anything else such as certain drugs? If yes, please explain: _____	<input type="checkbox"/>	<input type="checkbox"/>
How would you describe the child's eating habits? _____		
Has the child ever had a serious illness? If yes, when _____ please describe _____	<input type="checkbox"/>	<input type="checkbox"/>
Has the child ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>
Has the child ever received general anesthesia?	<input type="checkbox"/>	<input type="checkbox"/>
Does the child have any speech difficulties?.....	<input type="checkbox"/>	<input type="checkbox"/>
Has the child ever had a blood transfusion?	<input type="checkbox"/>	<input type="checkbox"/>
Is the child physically, mentally, or emotionally impaired?	<input type="checkbox"/>	<input type="checkbox"/>
Does the child experience excessive bleeding when cut?	<input type="checkbox"/>	<input type="checkbox"/>
Is this the child's first visit to a dentist? If not the first visit, what was the date of the last dental visit? Date: _____	<input type="checkbox"/>	<input type="checkbox"/>
Has the child had any problem with dental treatment in the past?	<input type="checkbox"/>	<input type="checkbox"/>
Has the child ever had dental radiographs (x-rays) exposed?	<input type="checkbox"/>	<input type="checkbox"/>
Has the child ever suffered any injuries to the mouth, head or teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Has the child had any problems with the eruption or shedding of teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Has the child had any orthodontic treatment?	<input type="checkbox"/>	<input type="checkbox"/>
What type of water does your child drink? ____ City water ____ Well water ____ Bottled water ____ Filtered water		
Does the child take fluoride supplements?	<input type="checkbox"/>	<input type="checkbox"/>
Is fluoride toothpaste used?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
Does child participate in active recreational activities?	<input type="checkbox"/>	<input type="checkbox"/>

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

- | | | |
|---|--|---|
| <ul style="list-style-type: none"> <input type="radio"/> Anemia <input type="radio"/> Arthritis <input type="radio"/> Asthma <input type="radio"/> Bladder <input type="radio"/> Bleeding Disorders <input type="radio"/> Bone/Joints <input type="radio"/> Cancer <input type="radio"/> Cerebral Palsy <input type="radio"/> Chicken Pox <input type="radio"/> Chronic Sinusitis <input type="radio"/> Diabetes <input type="radio"/> Earaches <input type="radio"/> Epilepsy | <ul style="list-style-type: none"> <input type="radio"/> Fainting <input type="radio"/> Growth Problems <input type="radio"/> Hearing <input type="radio"/> Heart <input type="radio"/> Hepatitis <input type="radio"/> HIV + / AIDS <input type="radio"/> Immunizations <input type="radio"/> Kidney <input type="radio"/> Latex Allergy <input type="radio"/> Liver <input type="radio"/> Measles <input type="radio"/> Mononucleosis <input type="radio"/> Mumps | <ul style="list-style-type: none"> <input type="radio"/> Pregnancy (Teens) <input type="radio"/> Rheumatic Fever <input type="radio"/> Seizures <input type="radio"/> Sickle Cell <input type="radio"/> Thyroid <input type="radio"/> Tobacco / Drug Use <input type="radio"/> Tuberculosis <input type="radio"/> Venereal Disease <input type="radio"/> 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)