# Welcome to the office of Dr. Dennis W. Clark

Today's Date: ______________________ Email: ______________________________________ Male: ☐ Female: ☐
Patient's Name: ____________________________________ I prefer to be called: ___________________________
Birthdate: ___/___/_____ Age: ______ Last 4 digits of SSN: ___________________ ☐Single ☐ Married ☐ Separated
Home Address: ________________________________________ City: ____________ State ____ Zip code: ___________
Billing Address (if different): ____________________________ City: ____________ State: _____ Zip code: _________
Home Phone: (___) __________ Cell Phone: (___) _____________ Driver's License# _______________ State: _______
Who may we thank for referring you? _____________________________________________________________________
Other family members seen by us: _______________________________________________________________________
Employer: ______________________________ How long there? __________ Occupation: ________________________
Employer's Address: _________________________________________________Work Phone: (___) _________________

**Neighbor or Relative not living with you in case of emergency**

His/Her Name: ___________________________Relation: _____________Work#: ____________ Home#: ___________

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**Person Responsible for Account if not you**

Name: __________________________________ Relation: ______________________________ Birthdate__/___/___
Home Phone: (___) _______________ Cell Phone: (___) _______________ Driver's License # ____________________
Employer: _______________________________ Work Phone #:(___) ______________ Ext. _________

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## SPOUSE INFORMATION

His/Her Name: _____________________________ Birthdate: ___/____ /___ Last 4 digits of SSN: ___________________
Home Phone:(___) ____________________Cell Phone:(___) ____________________ Driver's License # ___________
Employer: ________________________________Work Phone #:(___) ___________________________ Ext. __________

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## INSURANCE INFORMATION

**Primary Dental Insurance** Orthodontic Coverage? Yes ☐ No ☐
Insurance Co. Name: _________________________________________________ Phone #:(___) ____________________
ID #: ____________________________________ Group #: ___________________
Insured's Name: ______________________________ Social Security #: _________________ Birthdate: ___ / ___ / _____
Insured's Employer: _______________________________________Employer's Phone #: (___) _____________________

**Secondary Dental Insurance** Orthodontic Coverage? Yes ☐ No ☐
Insurance Co. Name: _________________________________________________ Phone #:(___) ____________________
ID #: ____________________________________ Group #: ___________________
Insured's Name: ______________________________ Social Security #: _________________ Birthdate: ___ / ___ / _____
Insured's Employer: _______________________________________Employer's Phone #: (___) _____________________

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In consideration of our employees and other patients, we ask that you refrain from wearing any type of fragrances to your appointments.

*We require a minimum of 24 hours' notice to reschedule an appointment. A $40.00 fee may be assessed on your account for any appointment missed without adequate notice. We do not allow repeated cancellations or short-notice changes.*

X ______________________________________________ ____________________________
Patients signature, or Parent's signature if patient is a minor Date

# Health History Form

| Patient's Name: | Today's Date: |
|---|---|
| If you are completing this form for another person, what is your relationship to that person? | |
| **Your name:** | **Relationship:** |

## Dental Information

| | |
|---|---|
| Date of your last dental x-rays/exam: | Who was your previous dentist? |
| Date of last cleaning: | Why did you leave your previous dentist? |
| What is your reason for your dental visit today? | Please rate your smile: *(circle one)*<br>1 2 3 4 5 6 7 8 9 10<br>If there is anything you would change, what would it be? |

## Medical Questions – For the following questions, please mark (X) your responses to the following questions (DK = Don't Know):

| Question | Yes | No | DK |
|---|---|---|---|
| Do your gums bleed when you brush or floss? | ☐ | ☐ | ☐ |
| Are your teeth sensitive to cold, sweets, or pressure? | ☐ | ☐ | ☐ |
| Is your mouth dry? | ☐ | ☐ | ☐ |
| Have you had any periodontal (gum) treatments? | ☐ | ☐ | ☐ |
| Have you ever had orthodontic (braces) treatment? | ☐ | ☐ | ☐ |
| Do you have any loose teeth? | ☐ | ☐ | ☐ |
| Do you have anxiety toward dental treatment? | ☐ | ☐ | ☐ |
| Have you had any problems associated with previous dental treatment? List: | ☐ | ☐ | ☐ |
| Have tonsils and adenoids been removed? | ☐ | ☐ | ☐ |
| Have you ever sucked a thumb/fingers? | ☐ | ☐ | ☐ |
| Do you grind your teeth? | ☐ | ☐ | ☐ |
| Do you now or have you ever experienced popping, discomfort, or clicking in your jaw? | ☐ | ☐ | ☐ |
| Have you ever had a serious injury to your head or mouth? | ☐ | ☐ | ☐ |
| Do you experience ringing in your ears? | ☐ | ☐ | ☐ |
| Are you currently experiencing dental pain or discomfort? | ☐ | ☐ | ☐ |
| Do you have speech problems? | ☐ | ☐ | ☐ |
| Are there missing or extra permanent teeth? | ☐ | ☐ | ☐ |

## Medical Information – *Please mark (X) your responses to indicate if you have or have not had any of the following diseases or problems.*

Are you now under the care of a physician………………. Yes ☐ No ☐ DK ☐

Physician Name: Phone: (_____) ____________________

Address/City/State/Zip:

Are you in good health?....... Yes ☐ No ☐ DK ☐

Has there been any change in your general health within the past year?....... Yes ☐ No ☐ DK ☐

If yes, what condition was being treated?

Date of last physical exam:

Pharmacy Name: Phone:

Do you use tobacco (smoking, snuff, chew, vapor)?....... Yes ☐ No ☐ DK ☐

If smoking, how many packs per packs per day do you smoke? ____________

If so, how interested are you in stopping? (circle)

VERY / SOMEWHAT / NOT INTERESTED

Do you drink alcoholic beverages? ……… Yes ☐ No ☐ DK ☐

If yes, how much do you typically drink in a week? ______________________

**WOMEN ONLY**: Are you:

Pregnant?....... Yes ☐ No ☐ DK ☐

Number of weeks: ______________________

Nursing?....... Yes ☐ No ☐

Taking birth control pills or hormonal replacement?........... Yes ☐ No ☐

Have you had a serious illness, operation, or been hospitalized in the past 5 years?....... Yes ☐ No ☐ DK ☐

If yes, what was the illness or problem?

Do you use a wheelchair or walker?....... Yes ☐ No ☐ DK ☐

Are you taking any prescription or over the counter medicines?....... Yes ☐ No ☐ DK ☐

If so, please list all medications, including vitamins, natural or herbal preparations, and/or diet supplements (attach list if necessary):

_______________________________________________

_______________________________________________

_______________________________________________

_______________________________________________

_______________________________________________

_______________________________________________

_______________________________________________

**Are you taking the following medications?**

| Medication | Yes | No | DK |
|---|---|---|---|
| Anti-anxiety or anti-depressant | ☐ | ☐ | ☐ |
| Muscles relaxers | ☐ | ☐ | ☐ |
| Insulin | ☐ | ☐ | ☐ |
| Blood thinners | ☐ | ☐ | ☐ |
| Pain killers | ☐ | ☐ | ☐ |
| Tranquilizers | ☐ | ☐ | ☐ |
| Blood Pressure Meds | ☐ | ☐ | ☐ |

Continued on next page ➡

## Medical Information Cont. - *Please mark (X) your responses to indicate if you have or have not had any of the following diseases or problems.*

Allergies – Are you allergic to or have you had a reaction to any of the following:

| | Yes | No | DK | | Yes | No | DK | | Yes | No | DK |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Dental Anesthetics | ☐ | ☐ | ☐ | Aspirin | ☐ | ☐ | ☐ | Sedatives | ☐ | ☐ | ☐ |
| Amoxicillin | ☐ | ☐ | ☐ | Ibuprofen | ☐ | ☐ | ☐ | Sulfa Drugs | ☐ | ☐ | ☐ |
| Erythromycin | ☐ | ☐ | ☐ | Jewelry/Metals | ☐ | ☐ | ☐ | Barbiturates | ☐ | ☐ | ☐ |
| Codeine | ☐ | ☐ | ☐ | Latex | ☐ | ☐ | ☐ | | | | |

Other: ________________________________

Joint Replacement: Have you had any orthopedic total joint (hip, knee, elbow, finger) replacement? ……………………………………….. Yes ☐ No ☐ DK ☐

Date: _______________________________ If yes, have you had any complications? ________________________________________________

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

| Name of physician or dentist making recommendation: | Phone:<br>(_____) ______________________________ |
|---|---|

## Medical Conditions: *Please mark (X) your responses to indicate if you have or have not had any of the following diseases or problems.*

| | Yes | No | DK | | Yes | No | DK | | Yes | No | DK |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Artificial Heart Valves | ☐ | ☐ | ☐ | Drug Abuse | ☐ | ☐ | ☐ | Auto Immune Disease | ☐ | ☐ | ☐ |
| Heart Murmur | ☐ | ☐ | ☐ | Emphysema/COPD | ☐ | ☐ | ☐ | Mitral Valve Prolapse | ☐ | ☐ | ☐ |
| Abnormal Bleeding | ☐ | ☐ | ☐ | Epilepsy | ☐ | ☐ | ☐ | Pacemaker | ☐ | ☐ | ☐ |
| Alcohol/Drug Abuse | ☐ | ☐ | ☐ | Frequent Neck Pain | ☐ | ☐ | ☐ | Psychiatric Problems | ☐ | ☐ | ☐ |
| Arthritis/Rheumatism | ☐ | ☐ | ☐ | Glaucoma | ☐ | ☐ | ☐ | Radiation Treatment | ☐ | ☐ | ☐ |
| Artificial bones/Joints | ☐ | ☐ | ☐ | Headaches | ☐ | ☐ | ☐ | Rheumatic Fever | ☐ | ☐ | ☐ |
| Asthma/Hay Fever | ☐ | ☐ | ☐ | Heart Attack | ☐ | ☐ | ☐ | Respiratory Problems | ☐ | ☐ | ☐ |
| Autism/ADD/ADHD | ☐ | ☐ | ☐ | Heart Surgery | ☐ | ☐ | ☐ | Shingles | ☐ | ☐ | ☐ |
| Back Problems | ☐ | ☐ | ☐ | Hepatitis (type ______) | ☐ | ☐ | ☐ | Sinus Problems | ☐ | ☐ | ☐ |
| Cancer | ☐ | ☐ | ☐ | High Blood Pressure | ☐ | ☐ | ☐ | Sleep Apnea | ☐ | ☐ | ☐ |
| Chemotherapy | ☐ | ☐ | ☐ | Low Blood Pressure | ☐ | ☐ | ☐ | Stroke | ☐ | ☐ | ☐ |
| Chest Pain | ☐ | ☐ | ☐ | HIV+/AIDS/ARC | ☐ | ☐ | ☐ | Thyroid Problems | ☐ | ☐ | ☐ |
| Choke on Liquids | ☐ | ☐ | ☐ | Jaw Problems/TMJ/TMD | ☐ | ☐ | ☐ | Tuberculosis (TB) | ☐ | ☐ | ☐ |
| Congenital Heart Defect | ☐ | ☐ | ☐ | Kidney Disease | ☐ | ☐ | ☐ | Ulcers | ☐ | ☐ | ☐ |
| Diabetes | ☐ | ☐ | ☐ | Liver Disease | ☐ | ☐ | ☐ | Venereal Disease | ☐ | ☐ | ☐ |
| Difficult Breathing | ☐ | ☐ | ☐ | | | | | | | | |

Do you have any disease, condition, or problem not listed above that you think I should know about?………………………………………… Yes ☐ No ☐ DK ☐

Please explain:

I certify that I have read and understand the above and that the information given in this form is accurate. I understand the importance of a truthful health history and that my dentist and his 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 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. I authorize the dental staff to perform the necessary dental services that I need.

| **Signature of Patient/Legal Guardian:**<br>X ______________________________________________ | **Date:**<br>__________________________________________ |
|---|---|

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**Medical Update:** I have reviewed my health history and confirm that it adequately states past and present conditions.

| Date | Please Explain | Patient's Signature | Doctor's Initials |
|---|---|---|---|
| ________ | ________ | ________ | ________ |
| ________ | ________ | ________ | ________ |
| ________ | ________ | ________ | ________ |
| ________ | ________ | ________ | ________ |

# Consent for Services and Patient Financial Agreement

We invite you to ask questions regarding your dental treatment. The best dental health services are based on a friendly, mutual understanding between provider and patient. Dr. Clark's treatment recommendations are based upon what he believes are in your best interest, rather than on what your insurance covers.

I authorize Dr. Clark's office to perform any necessary services needed during diagnosis and treatment. I also authorize the release of any information required to process insurance claims or prepare referrals to another provider of services.

I acknowledge and understand I am financially responsible for all charges and agree to pay, whether or not insurance is involved. Dr. Clark requires payment in full for all services rendered at the time of visit, including co-pays and deductibles, unless other arrangements have been made with the account manager. Accounts 90+ days overdue will be subject to a 1.5% monthly finance charge. If account is not paid within 90 days of the date of service and no financial arrangements have been made, your account will be forwarded to a collection agency.

I understand I am responsible for legal fees, collection fees, interest charges and any other expenses occurred in collecting the unpaid balance. A $35.00 fee will be assessed for any check returned for Non-Sufficient Funds.

I understand the above information and guarantee all forms were completed correctly to the best of my knowledge. I also understand it is my responsibility to inform this office of any changes to the information I have provided. I have read the above Consent for Services and Financial Agreement and agree to their content.

X ______________________________________________ ____________________

Patient’s signature, or Parent's signature if patient is a minor Date