

Medical Alert:

Premedication:

Allergies:

DENTAL HISTORY

How would you describe your current dental problem?
Do you receive dental care on a routine basis? (Yes / No) Date of Last visit:
Do you use a manual or electric toothbrush? How many times per day?
Do you floss your teeth on a routine basis? (Yes / No) How many times per week?
Do your gums ever bleed? (Yes / No) Discuss
Have you ever received scaling and root planning (Deep Cleaning)? (Yes / No) When?
Do you wear removable dental appliances? (Yes / No) If yes, please list:
Do you feel nervous or anxious about having dental treatment? (Yes / No)
Do you want to keep your remaining teeth? (Yes / No)
Do you ever clench, grit or grind your teeth? (Yes / No) Discuss
Do you ever have clicking, popping or discomfort in the jaw joints (TMJ)? Yes / No Discuss
Have you had orthodontic treatment? (Yes / No) If yes, which office and when:
Have you ever considered having your teeth straightened or whitened? (Yes / No) Discuss
Is there anything about your smile you would like to change or improve?

MEDICAL INFORMATION

Medical doctor's Name Phone #
Are you currently under the care of a physician? (Yes / No) If Yes, why?
Are you taking any medications, prescribed or over-the-counter, including vitamins, supplements and contraceptives? Please List:
What is your preferred pharmacy? Phone Number:
Are you allergic to any medications or substances such as latex, codeine, etc? (Yes / No) List:
Has a physician or previous dentist recommended that you take antibiotics prior to dental treatment? (Yes / No)
If yes, what medication and for what condition?
Do you use tobacco (smoking, snuff, chew)? (Yes / No) Frequency:
How interested are you in stopping? (Very / Somewhat / Not Interested)
For women to answer: Are you pregnant (Yes / No) Due date:
Trying to become pregnant? (Yes / No) Nursing? (Yes / No)

Please circle if have or have had any of the following:

Table with 5 columns of medical conditions: Abnormal Bleeding, ADD/ADHD, AIDS, Allergies, Anemia, Anxiety, Arthritis/Gout, Artificial Heart Valve, Artificial Joints/Hips, Asthma, Autism, Blood Disease, Blood Transfusion, Bruise Easily, Cancer, Chemotherapy/Radiation, Chest Pain, Cold Sores, Congenital Heart Lesion, Cortisone Medicine, Depression, Diabetes: Type, Drug Addiction, Dry Mouth, Eating Disorder, Emphysema, Epilepsy or Seizures, Excessive Thirst, Fainting or Dizziness, Frequent Cough, Fever Blisters, Glaucoma, Hay Fever, Heart Murmur, Heart Pacemaker, Heart Surgery, Heart Trouble, Hemophilia, Hepatitis, Herpes, High Blood Pressure, Hypoglycemia, Kidney Trouble, Liver Disease, Low Blood Pressure, Lung Disease, Mental Health Disorder, Nervousness, Pain in jaw joints, Parathyroid Disease, Psychiatric Care, Rheumatism, Sickle Cell Anemia, Scarlet Fever, Sinus Trouble, Shortness of breath, Stroke, Swelling of Feet/Ankles, Hands, Thyroid Disease, Tuberculosis, Ulcers, Venereal Disease, X-ray or Cobalt Treatment, Yellow Jaundice

Have you ever had any other serious illness, condition or surgery not listed above? (Yes / No) If yes, please list with dates:

I certify that I have read and understand the above. 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 at the next appointment without fail.

X Signature of Patient, Parent or Guardian Date

Reviewed by Doctor/RDH Date

Date: _____

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ADULT HEALTH HISTORY FORM

Name: _____
Last First Middle

Preferred Name: _____ Previous Name: _____ Male Female

Birth date: _____ Social Security Number: _____

CONTACT INFORMATION

HOME ADDRESS

Best time to contact me is: AM PM
On my: Home Cell Work

TELEPHONE

Home _____
Cell _____
Work _____ Ext. _____
Email: _____
Name of Employer: _____

INSURANCE INFORMATION

Insurance Subscriber's Information

Dental Insurance Co. Customer Service Phone #

Subscriber's Name Employer

Date of Birth Relationship to Patient

SSN or Member ID # Group #

**Secondary Insurance Information
(If applicable)**

Dental Insurance Co. Customer Service Phone #

Subscriber's Name Employer

Date of Birth Relationship to Patient

SSN or Member ID # Group #

REFERRAL TRACKING: HOW DID YOU HEAR ABOUT OUR OFFICE?

Current Patient of ours Name _____
 Drove by and saw office
 Doctor Name _____
 Phone Book
 Other: Please specify _____
 Internet

EMERGENCY CONTACT

Name Relationship to Patient

Home Phone Alternate Phone

ACCOUNT PREFERENCES

Who is responsible for paying for this account?

Would you like to receive your monthly statements by e-mail? Yes No

At Huckabee & Huckabee our office policy is payment at the time of service. If insurance is involved we will expect your estimated percentage. Our office will not be held responsible for inaccurate insurance estimates. We require a 24-hour notice for any appointment change. If 24-hour notice is not received, there will be a cancellation fee added to your account. This charge is not a covered benefit by your insurance company and will be your responsibility. We will not be able to reschedule any dental appointments until the charge is paid. Monthly late charges will be added to any unpaid balance after 60 days at the rate of 18% APR of the unpaid balance. If a personal check for any payment is returned unpaid, you will be charged a returned check fee of \$25.00. If it becomes necessary to turn this account over for professional collection, you will be responsible for their charges as well as your unpaid balance for our services. Should it become necessary to take legal action to collect any unpaid balance, you will be charged for any expenses incurred in connection with such action, including reasonable attorney's fees.

Authorization

I hereby authorize payment directly to Huckabee & Huckabee DDS for group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize Huckabee & Huckabee DDS to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history (on reverse) are correct to the best of my knowledge.

Signature of Responsible Party _____ Date _____

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