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:

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

Reviewed by Doctor/RDH_________________________________ **Date** ____________________________

Medical Alert:	Premedication:	Allergies:

Date: ___________________________

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______________________
□Doctor
Name______________________
□Other: Please specify
____
□Drove by and saw office
□Phone Book
□Internet

EMERGENGY 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 cancelation 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**__________________________

Continued on other side