HEATH DENTAL GROUP

WILLIAM H. HEATH, D.D.S.
info@heathdentalgroup.com

3759 Constellation Road
Lompoc, CA 93436 • (805) 733-4574

PATIENT INFORMATION

Patient Name: _____ Date: _____
LAST FIRST MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other

Social Security # _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Cell: _____

Email: _____

Address: _____
STREET APARTMENT #

_____
CITY STATE ZIP CODE

Emergency Contact: _____ Phone: _____

RESPONSIBLE PARTY • Insurance Information

PRIMARY INSURANCE

Name of Insured: _____ Is Insured a Patient? ☐ Yes ☐ No
LAST FIRST MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
STREET CITY STATE ZIP CODE

Insured's Employer Name: _____ Phone: _____

Address: _____
STREET CITY STATE ZIP CODE

Patient's relationship to Insured: Name of Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

SECONDARY INSURANCE

Name of Insured: _____ Is Insured a Patient? ☐ Yes ☐ No
LAST FIRST MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
STREET CITY STATE ZIP CODE

Insured's Employer Name: _____ Phone: _____

Address: _____
STREET CITY STATE ZIP CODE

Patient's relationship to Insured: Name of Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

CONSENT FOR SERVICES

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time the services are performed. There will be a 3.5% surcharge for credit card payments.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. Signature authorizes release of any information necessary to process any insurance claim and authorizes payment of benefits to Heath Dental Corporation or William H. Heath, D.D.S.

A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 90 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any line or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and agree to their content.

X _____ Date: _____ Relationship to Patient: _____

Signature of patient, parent or guardian

HEALTH HISTORY

Patient Name: **BIRTH DATE:**

I. CIRCLE APPROPRIATE ANSWER (leave blank if you do not understand question):

1. Yes No Is your general health good?
2. Yes No Has there been a change in your health within the last year?
3. Yes No Have you been hospitalized or had a serious illness in the last three years?
   If YES, why?_____
4. Yes No Are you being treated by a physician now? Name:_____For what? _____
   Date of last medical exam?_____Date of last dental exam?_____
5. Yes No Have you had problems with prior dental treatment?
6. Yes No Are you in pain now?

II. HAVE YOU EXPERIENCED:

7.	Yes	No	Chest pain (angina)?	15.	Yes	No	Dizziness? Fainting?
8.	Yes	No	Shortness of breath?	16.	Yes	No	Ringing in ears?
9.	Yes	No	Persistent cough, coughing up blood?	17.	Yes	No	Headaches?
10.	Yes	No	Bleeding problems, bruising easily?	18.	Yes	No	Blurred vision?
11.	Yes	No	Sinus problems?	19.	Yes	No	Seizures?
12.	Yes	No	Difficulty swallowing?	20.	Yes	No	Excessive thirst? Dry mouth?
13.	Yes	No	Diarrhea, constipation, blood in stools?	21.	Yes	No	Joint pain, stiffness?
14.	Yes	No	Frequent vomiting, nausea?				

III. DO YOU HAVE OR HAVE YOU HAD:

22.	Yes	No	Heart disease?	31.	Yes	No	AIDS? STDs?
23.	Yes	No	Heart attack, heart defects?	32.	Yes	No	Tumors, cancer?
24.	Yes	No	Stroke, hardening of arteries?	33.	Yes	No	Arthritis, rheumatism?
25.	Yes	No	High blood pressure?	34.	Yes	No	Eye diseases?
26.	Yes	No	Asthma, TB, emphysema, other lung disease?	35.	Yes	No	Skin diseases?
				36.	Yes	No	Anemia?
27.	Yes	No	Hepatitis, other liver disease?	37.	Yes	No	Herpes?
28.	Yes	No	Stomach problems, ulcers?	38.	Yes	No	Thyroid, adrenal disease?
29.	Yes	No	Allergies to: drugs, food, medications, latex or anesthetics?	39.	Yes	No	Diabetes?
				40.	Yes	No	Clench or grind teeth?
30.	Yes	No	Family history of diabetes, heart problems, tumors?	41.	Yes	No	Breathe through your mouth most of the time?
				42.	Yes	No	Feel restless after full nights sleep?
				43.	Yes	No	Snore?

IV. DO YOU HAVE OR HAVE YOU HAD:

44.	Yes	No	Psychiatric care?	49.	Yes	No	Hospitalization?
45.	Yes	No	Radiation treatments?	50.	Yes	No	Blood transfusions?
46.	Yes	No	Chemotherapy?	51.	Yes	No	Surgeries?
47.	Yes	No	Prosthetic heart valve?	52.	Yes	No	Pacemaker?
48.	Yes	No	Artificial joint?				

V. ARE YOU TAKING:

53.	**Yes**	**No**	**Recreational drugs?**	**55.**	**Yes**	**No**	**Tobacco in any form?**
54.	**Yes**	**No**	**Drugs, medications, over-the-counter medicines (including Aspirin), natural remedies?**	**56.**	**Yes**	**No**	**Alcohol?**

Please list: _____

_____

VI. WOMEN ONLY:

57.	**Yes**	**No**	**Are you or could you be pregnant or nursing?**	**58.**	**Yes**	**No**	**Taking birth control pills?**

VII. ALL PATIENTS:

59. Yes No Do you have or have you had any other diseases or medical problems NOT listed on this form?

If so, please explain: _____

_____

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.

PATIENT'S SIGNATURE X _____Date: _____ Dr. Signature: _____

RECALL REVIEWS:

1. Patient's signature _____Date: _____Dr. Signature: _____

2. Patient's signature _____Date: _____Dr. Signature: _____