ABBADENT PATIENT INFORMATION AND HEALTH HISTORY

Date ____________

Patient Name ______________________ Email ________________ Date of Birth __________

Single Married

Dental History

Primary Oral Concern ____________ Date of Last Dental Exam ______ What would you like to change about your smile? ______________ What is most important to you about your oral health? ________

__________ What do you consider the most important quality in a dentist? ____________

DO YOU HAVE OR DO YOU USE ANY OF THE FOLLOWING?

__ Teeth sensitive to cold, heat, sweets or pressure
__ Cigarettes, pipe, cigar or chewing tobacco
__ Bleeding gums or loose teeth
__ Clenching or grinding
__ Burning of tongue
__ Swelling or lumps in the mouth
__ Frequent blisters on lips or mouth
__ Pain or sounds in ear while eating
__ Bad Breath
__ Unpleasant taste
__ Periodontal treatment
__ Food impaction
__ Orthodontic treatment
__ Mouth breathing
__ Alcoholic drinks
__ Unfavorable Dental Experience
__ Texture of toothbrush ________
__ Frequency of brushing ________
__ Dental floss
__ Water jet device
__ Mechanical toothbrush
__ Fingernail biting

Medical History

Physician's name ______________ Date of last Physical exam ____________ Your present age ____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

__ Are you ***currently pregnant*** __ Have you ever been told you need **premedication prior to dental treatment**

__ Immune system disorders (AIDS, HIV, ARC)
__ Allergies to drugs
__ Any heart ailments __ Heart murmurs
__ Neurological problems
__ Excessive bleeding from cut or extraction
__ Anemia or blood problems
__ Alcoholic drinks
__ High blood pressure
__ Mental health care
__ Kidney dialysis
__ Active cancer/tumor
__ Organ transplant
__ Hay fever/allergies
__ Kidney problems
__ Bone strengthening med
__ Rheumatic fever
__ Ulcer or colitis
__ ***Latex sensitive***
__ Radiation treatments
__ Artificial valves
__ Rheumatoid Arthritis
__ Mitral valve prolapse
__ Asthma
__ Venereal disease
__ Diabetes
__ Malignancies
__ Sinus problems
__ Liver problems
__ Lupus
__ Joint replacement
__ Artificial shunt
__ Pacemaker/Defibulator
__ Substance abuse
__ Thyroid
__ Glaucoma
__ Tonsillitis
__ Tuberculosis
__ Chemotherapy
__ Stroke
__ Hepatitis
__ Aneurysm
__ Artificial stent
__ Osteoporosis
__ Other

Describe any current treatment and drugs you are taking, even though not listed above ______________

____

APPOINTMENTS: A minimum charge may be made for failed or cancelled appointments without prior notification of 24 hours.

INSURANCE: To avoid misunderstandings regarding your insurance, we wish patients to know that all professional services are charged directly to the patient and patients are personally responsible for payment of fees. We may prepare necessary forms or reports to help you obtain your benefits from insurance companies, upon receipt of full (or partial) payment of bill at the time of treatment. We do not render our services on the basis that insurance companies will pay for all our fees or that we must comply with UCR schedules. Each fee is individual for the individual patient. We consider all insurance payments assigned to us as having come from the patient or guardian, therefore erroneous insurance payments made to us will be the patient's responsibility to pay back to the insurance company. You authorize release of any information relating to your dental claims. You hereby authorize payment of the dental benefits otherwise payable to you directly to the above named dental entity. By signing below you agree to these terms and certify the truth of information you gave us on this form

Signature of patient (or guardian if a minor) ____________________ Date ______