HEALTH HISTORY

Patient _____ _____ Date_____
First Last

DOB _____ MALE☐ FEMALE☐ OTHER ☐ Preferred Name_____

Are you in good health?.....Y☐ N☐
Has there been any change in your general health in the past 5 years?.....Y☐ N☐
Date of last physical examination……_____
Are you under the care of a physician for a particular problem?.....Y☐ N☐

If so, Physician's name and phone number_____

Have you ever had any serious illnesses, operations, or hospitalizations?.....Y☐N☐
If so, please describe:

Are you using any of the following medications?

Antibiotics	Y☐N☐	Steroids	Y☐N☐
Blood thinners	Y☐N☐	Tranquilizers	Y☐N☐
Aspirin or Ibuprofen	Y☐N☐	Insulin/Oral diabetes meds	Y☐N☐
High blood pressure	Y☐N☐	Heart medications	Y☐N☐

Are you using or have you used in the past …… Fosamax or similar **Y☐N☐**

***Please list <u>ALL</u> medications and doses, including prescriptions, over the counter medications, herbal remedies, vitamins, etc…**

Are you taking **Coumadin (Warfarin)** ? Y☐ N☐

Are you allergic or had an adverse reaction to:

Local anesthesia	Y☐N☐	**Latex/rubber products**	**Y☐N☐**
Penicillin or other antibiotics	**Y☐N☐**	Sulfites	Y☐N☐
Sedatives or barbiturates	Y☐N☐	Dairy	Y☐N☐
Aspirin or Ibuprofen	Y☐N☐	Nuts	Y☐N☐
Codeine or other pain killers	Y☐N☐	Other	

Do you smoke or chew tobacco?.....Y☐N☐

Is there any past or current history of alcohol, chemical dependency or emotional disorder that may affect the care we provide you?.....Y☐N☐
Have you ever had any serious problems with any previous dental treatment?.....Y☐N☐

Do you have or have you ever had any of the following?

Rheumatic fever or rheumatic heart disease……	Y☐ N☐
Congenital heart disease……..	Y☐ N☐
Cardiovascular disease (heart attack, murmur, coronary artery disease, angina, stroke,… high blood pressure, palpitations, heart surgery, pacemaker) circle which one	**Y☐ N☐**
Lung disease (asthma, emphysema, chronic cough, bronchitis, tuberculosis……. shortness of breath, chest pain, severe coughing)circle which one	
Seizures, convulsions, epilepsy, fainting or dizziness……..	Y☐ N☐
Bleeding disorder, anemia, bleeding tendency…….	Y☐ N☐
Do you bruise easily? ……..	Y☐ N☐
Liver disease (jaundice, hepatitis)circle which one…..…….....	Y☐ N☐
Kidney disease……..	Y☐ N☐
Diabetes…….	Y☐ N☐
Thyroid disease……..	Y☐ N☐
ADHD or ADD……..	Y☐ N☐
Arthritis……..	Y☐ N☐
Stomach ulcers or colitis…….....	Y☐ N☐
Glaucoma……...	Y☐ N☐
Implants placed anywhere in your body(pacemaker, heart valve, knee, hip)circle which one	**Y☐ N☐**
Radiation treatment or chemotherapy……	Y☐ N☐
Clicking or popping of jaw joint, pain near ear, difficulty opening mouth……	Y☐ N☐
Grind or clench teeth……...	Y☐ N☐
Sinus or nasal problems……..	Y☐ N☐
Any disease, drug or transplant operation that has depressed your immune system……..	Y☐ N☐
Do you have any other disease, condition or problem not listed above that……..... you think the doctor should know about? Please explain if YES	Y☐ N☐

Do you wish to speak privately to the doctor about anything?.....	Y☐ N☐
I understand the importance of a truthful Health History in assisting…….. the doctor in providing the best care possible	Y☐ N☐

FOR WOMEN ONLY:

Are you pregnant, or is there any chance you might be pregnant?.....	Y☐ N☐
Are you nursing?.....	Y☐ N☐

If you are using oral contraceptives, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Please consult with your physician for further guidance.

Date _____ Patient/Guardian Signature _____ Doctor/Hygienist initials _____

Insurance and Financial Information

Our practice strives to treat our patients with the best possible care under all circumstances. We are committed to offer you a range of treatment possibilities, when appropriate, and can often tailor these options to best fit your needs and wishes.

Many questions arise during the examination and treatment process regarding our financial policy and the role of dental insurance.
While we will be glad to submit a claim to your insurance, this does not necessarily mean that our office "participates" with that company. We strongly encourage you to determine if our office is a participating provider prior to your examination.

To file an insurance claim on your behalf, we kindly request that you provide your insurance information in advance of your appointment. If this information is not available, payment is due in full at the time of service. We accept cash, personal checks, debit cards, Visa, and MasterCard. We gladly offer pre-treatment estimates. Please be aware that this is an estimate only, and charges may actually be higher or lower, depending on the nature of your procedure. A $20 charge plus bank fees will be assessed for any returned checks.

Insurance companies often differ in their policies regarding coverage of services that a doctor's office may provide. For this reason, your policy may require you (the subscriber) to pay nothing, a deductible, co-pay, co-insurance or may require you to pay for the entire procedure, depending on the policy language. **Please be aware that your policy is a contract between you and the insurance company, not Alan J Chebuske D.M.D & Catalina Y Atienza D.M.D.**
While we will gladly file a claim on your behalf, you are ultimately responsible for charges incurred. If your insurance company does not pay your claim within thirty days, the payment becomes your responsibility.

Charges for services are due and payable when the services are provided. Invoices unpaid after 60 days will be subject to a late fee of 24% per year, or 2% per month, on the unpaid balance.

If you have any questions regarding our policy please contact us.

PERSON RESPONSIBLE FOR THIS ACCOUNT

I authorize assigned insurance benefits payable for services DIRECTLY to ALAN J. CHEBUSKE D.M.D & CATALINA Y. ATIENZA D.M.D. This authorization shall also serve as a release of any information necessary to complete processing of any claims submitted on my behalf, and allow release of my x-rays or summary of the doctor's findings and treatment to other health-care providers. I understand that this authorization shall serve as valid for up to one year or expire should my policy change.

I UNDERSTAND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT OF THESE SERVICES.

I ALSO UNDERSTAND THAT SHOULD MY INSURANCE COMPANY NOT HONOR A CLAIM WITHIN 60 DAYS; it becomes my responsibility to pay Alan J. Chebuske D.M.D & Catalina Y Atienza D.M.D

Printed Name _____ Relationship to Patient _____

SIGNED _____ Date_____