Health History Form

ADA American Dental Association®
America's leading advocate for oral health

Email: Today's Date:

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: *Last* *First* *Middle*
Home Phone: *Include area code* ( )
Business/Cell Phone: *Include area code* ( )

Address: *Mailing address*
City: State: Zip:

Occupation: Height: Weight: Date of Birth: Sex: M F

SS# or Patient ID: Emergency Contact: Relationship: Home Phone: *Include area code* ( ) Cell Phone: *Include area code* ( )

If you are completing this form for another person, what is your relationship to that person?

Your Name *Relationship*

Do you have any of the following diseases or problems: *(Check DK if you Don't Know the answer to the the question)*

	Yes	No	DK
Active Tuberculosis	☐	☐	☐
Persistent cough greater than a 3 week duration	☐	☐	☐
Cough that produces blood	☐	☐	☐
Been exposed to anyone with tuberculosis	☐	☐	☐

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Dental Information *For the following questions, please mark (X) your responses to the following questions.*

	Yes	No	DK
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐
Do you drink bottled or filtered water?	☐	☐	☐
If yes, how often? *Circle one:* DAILY / WEEKLY / OCCASIONALLY			
Are you currently experiencing dental pain or discomfort?	☐	☐	☐

	Yes	No	DK
Do you have earaches or neck pains?	☐	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Do you brux or grind your teeth?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Do you participate in active recreational activities?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐

Date of your last dental exam:
What was done at that time?

Date of last dental x-rays:

What is the reason for your dental visit today?

How do you feel about your smile?

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

	Yes	No	DK
Are you now under the care of a physician?	☐	☐	☐

Physician Name: Phone: *Include area code* ( )

Address/City/State/Zip:

Are you in good health?	☐	☐	☐
Has there been any change in your general health within the past year?	☐	☐	☐

If yes, what condition is being treated?

Date of last physical exam:

	Yes	No	DK
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐	☐

If yes, what was the illness or problem?

Are you taking or have you recently taken any prescription or over the counter medicine(s)?	☐	☐	☐

If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements:

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

(Check DK if you Don't Know the answer to the question)

	Yes	No	DK
Do you wear contact lenses?	☐	☐	☐
Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	☐	☐	☐
Date: _____ If yes, have you had any complications? _____			
Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax®, Actonel®, Atelvia, Boniva®, Reclast, Prolia) for osteoporosis or Paget's disease?	☐	☐	☐
Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia®, Zometa®, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?	☐	☐	☐
Date Treatment began: _____			

	Yes	No	DK
Do you use controlled substances (drugs)?	☐	☐	☐
Do you use tobacco (smoking, snuff, chew, bidis)?	☐	☐	☐
If so, how interested are you in stopping? *Circle one:* VERY / SOMEWHAT / NOT INTERESTED			
Do you drink alcoholic beverages?	☐	☐	☐
If yes, how much alcohol did you drink in the last 24 hours? _____			
If yes, how much do you typically drink i n a week? _____			
WOMEN ONLY Are you:			
Pregnant?	☐	☐	☐
Number of weeks: _____			
Taking birth control pills or hormonal replacement?	☐	☐	☐
Nursing?	☐	☐	☐

Allergies. Are you allergic to or have you had a reaction to:
To all **yes** responses, specify type of reaction.

	Yes	No	DK
Local anesthetics _____	☐	☐	☐
Aspirin _____	☐	☐	☐
Penicillin or other antibiotics _____	☐	☐	☐
Barbiturates, sedatives, or sleeping pills _____	☐	☐	☐
Sulfa drugs _____	☐	☐	☐
Codeine or other narcotics _____	☐	☐	☐
Metals _____	☐	☐	☐
Latex (rubber) _____	☐	☐	☐
Iodine _____	☐	☐	☐
Hay fever/seasonal _____	☐	☐	☐
Animals _____	☐	☐	☐
Food _____	☐	☐	☐
Other _____	☐	☐	☐

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No	DK
Artificial (prosthetic) heart valve	☐	☐	☐
Previous infective endocarditis	☐	☐	☐
Damaged valves in transplanted heart	☐	☐	☐
Congenital heart disease (CHD)			
Unrepaired, cyanotic CHD	☐	☐	☐
Repaired (completely) in last 6 months	☐	☐	☐
Repaired CHD with residual defects	☐	☐	☐

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

	Yes	No	DK
Cardiovascular disease	☐	☐	☐
Angina	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Congestive heart failure	☐	☐	☐
Damaged heart valves	☐	☐	☐
Heart attack	☐	☐	☐
Heart murmur	☐	☐	☐
Low blood pressure	☐	☐	☐
High blood pressure	☐	☐	☐
Other congenital heart defects	☐	☐	☐
Mitral valve prolapse	☐	☐	☐
Pacemaker	☐	☐	☐
Rheumatic fever	☐	☐	☐
Rheumatic heart disease	☐	☐	☐
Abnormal bleeding	☐	☐	☐
Anemia	☐	☐	☐
Blood transfusion	☐	☐	☐
If yes, date: _____			
Hemophilia	☐	☐	☐
AIDS or HIV infection	☐	☐	☐
Arthritis	☐	☐	☐
Autoimmune disease	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Systemic lupus erythematosus	☐	☐	☐
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐
Tuberculosis	☐	☐	☐
Cancer/Chemotherapy/ Radiation Treatment	☐	☐	☐
Chest pain upon exertion	☐	☐	☐
Chronic pain	☐	☐	☐
Diabetes Type I or II	☐	☐	☐
Eating disorder	☐	☐	☐
Malnutrition	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
G.E. Reflux/persistent heartburn	☐	☐	☐
Ulcers	☐	☐	☐
Thyroid problems	☐	☐	☐
Stroke	☐	☐	☐
Glaucoma	☐	☐	☐
Hepatitis, jaundice or liver disease	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Neurological disorders	☐	☐	☐
If yes, specify: _____			
Sleep disorder	☐	☐	☐
Do you snore?	☐	☐	☐
Mental health disorders	☐	☐	☐
Specify: _____			
Recurrent Infections	☐	☐	☐
Type of infection: _____			
Kidney problems	☐	☐	☐
Night sweats	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistent swollen glands in neck	☐	☐	☐
Severe headaches/ migraines	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
Excessive urination	☐	☐	☐

	Yes	No	DK
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	☐	☐	☐

Name of physician or dentist making recommendation:

Phone: *Include area code*
( )

	Yes	No	DK
Do you have any disease, condition, or problem not listed above that you think I should know about?	☐	☐	☐

Please explain:

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: Date:

Signature of Dentist: Date:

FOR COMPLETION BY DENTIST

Comments:

FERRARA FAMILY
DENTISTRY

FERRARA FAMILY
DENTISTRY

Patient Information

Name: _____ Today's Date: _____

Date of Birth: _____ SSN: _____

How did you hear about our office? _____

If you are an existing patient: Any changes to these items since last visit? New patients, please skip to next section.

Email :_____

Address: _____

City: _____ State: _____ Zip: _____

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

Responsible Party (if different from the patient)

Person responsible for account: _____

Address: _____

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

Employer: _____ Relationship to patient: _____

Date of Birth: _____ SSN: _____ Email: _____

Primary Dental Insurance Information

Insurance company: _____ Phone: _____

Policy#: _____ Group #: _____

Name of insured person: _____ Employer: _____

Insured's date of birth: _____ SSN: _____

Authorization

I authorize my insurance company to pay Ferrara Family Dentistry LLC all insurance benefits payable to me for services rendered. The use of this signature grants permission for Ferrara Family Dentistry LLC to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges, whether or not paid by insurance.

Signature: _____ Date: _____

FERRARA FAMILY
DENTISTRY

Office Policies

We, the staff of Ferrara Family Dentistry LLC, thank you for choosing us as your dental health provider. We consider it a privilege to serve your needs, and we look forward to doing so. We are committed to providing you with the highest level of care and to building a successful provider-patient relationship with you and your family. We believe your understanding of our patients' financial responsibility is vital to that provider-patient relationship, and our goal is to not only inform you of the provisional aspects of that financial policy but also to keep the lines of communication open regarding them. If at any time you have any questions or concerns regarding our fees, policies, or responsibilities please feel free to contact our office at (985) 792-0515. We believe this level of communication and cooperation will allow us to continue to provide quality service to all of our valued patients.

Please understand that payment for services is an important part of the provider-patient relationship. If you do not have insurance, proof of insurance, or participate in a plan that will not honor an assignment of insurance benefits, payment for services will be due at the time of service unless a payment arrangement has been approved in advance.

We make payments as convenient as possible by accepting cash, money order, in-state checks, and many popular credit cards, including Care Credit. A $35.00 service fee will be charged for all returned checks.

We realize that temporary financial problems may affect timely payment of your account. If this should occur, please contact us for assistance in the management of your account. Our goal is to provide quality care and service. Please let us know immediately if you require any assistance or clarification from anyone within our business.

Insurance

Please remember that your insurance policy is a contract between you and your insurance carrier. We will, as a courtesy, bill your insurance for you and help work with you to receive the maximum allowable benefit under your policy. **We are not responsible for how your insurance company handles its claims or for what benefits they pay on a claim.** We can only assist you in estimating your portion of the cost of treatment. We at no time guarantee what your insurance will or will not do with each claim. We also can not be responsible for any errors in filing your insurance. Once again, we file claims as a courtesy to you. We have found that patients who are involved with their claims process are more successful at receiving prompt and accurate payment of services from their insurance carrier. We do expect patients to be interactive and responsible for communicating with insurance carriers on any open claims.

Please initial:_____

FERRARA FAMILY
DENTISTRY

It is your responsibility to provide all necessary insurance eligibility, identification, authorization and referral information and to notify our office of any information changes when they occur. We also require photo identification when accepting insurance information. It is the patient's responsibility to know if our office is participating or non-participating with their insurance plan. Failure to provide all required information may necessitate patient payment for all charges. When insurance is involved, we are contractually obligated to collect co-payments, co-insurance and deductibles, as outlined by your insurance carrier.

We do our best to provide estimates for dental services based on the information provided to us by your insurance company. Most insurance companies pay within 30 days. **Since the ultimate financial burden falls upon the patient, if after 60 days your insurance company will not pay on a properly filed claim, we will expect you to pay your fee in full.** From this point, we will work with you and help you file another claim or an appeal to have your claim paid by the insurance company so that you may be reimbursed.

Please be aware that out-of-network insurance carriers often prohibit assignment of benefits and may try to limit their financial liability with arbitrary limits, exclusions or reductions such as reasonable and customary our usual and prevailing reductions. Our fees are well within such ranges, and although we will assist in the filing of an appeal if these limitations are imposed, you as the guarantor are responsible for all out-of-network fees. If we are not contracted with your carrier, we will not negotiate reduced fees with your carrier.

Due to increasing costs and decreasing reimbursements, beginning January 1, 2016 we will no longer file secondary insurance. We will gladly help you with any documentation or information you may need to file claims to your secondary insurance company.

Medical Records Fees

Patients are entitled under federal law to have access to their protected health information, and we follow all rules, guidelines and exceptions to ensure compliance to patient rights. However, providers also have the right to compensation for records and our fees are a reasonable cost-based fee for copies including the copying, supplies, labor, and postage of the files and/or summaries.

Please initial:_____

FERRARA FAMILY
DENTISTRY

Missed Appointments

Just as we respect the busy schedule of our patients, we wish them to respect that we are busy as well, providing high quality dental care to lots of good folks like you. We require notice of cancellations 24 hours in advance. This allows us to offer the appointment to another patient. If you fail to keep your appointments without notifying us in advance, a missed appointment fee will apply. **These fees are typically $35.00 but not to exceed one-half the cost of your scheduled appointment and are based upon the amount of treatment time booked.** Repeated missed appointments without notification may cause you to be discharged from the practice so that we can provide efficient care to our other patients.

Treating Minors

It is our office policy that minors not be left unattended in the office. Patients who are under 18 years of age cannot consent to their own treatment and are not the financially-responsible party unless they are emancipated. Therefore, **a parent or legal guardian must remain in the office during any and all treatment**, including for dental cleanings. This is in the best interest of the patient in case a medical emergency arises and in the parents' best interest as we can communicate better with them about financial considerations when or if the treatment plan changes. Minors left unattended will not be treated.

Timeliness of Appointments

We try to see everyone in a timely manner, but if we are taking too long, please let our receptionist know so we can best serve your needs and reschedule you if necessary. Please know that in our industry, dental emergencies can and do occur and we try to see these patients as efficiently as possible. We appreciate your patience with any wait you may experience as a result of these emergencies. And please be aware: if you ever have need for treatment of a dental emergency, we will do everything we can to see you promptly and address the concern as best as we can.

Acknowledgement: I have read and understood the above office policy.

Signature of Patient or Authorized Representative: _____

Date: _____

FERRARA FAMILY
DENTISTRY

Privacy Policy and HIPAA

HIPAA (Health Insurance Portability and Accountability Act) requires healthcare providers and hospitals to protect patients' privacy and to ensure the security of the patient's health data. This process is known as HIPAA compliance. For more information, you can visit www.HIPAA.com or ask our front desk for a copy to review.

Please sign here acknowledging you have had a chance to review and understand the privacy policy. Thank you.

Name (Printed): _____

Signature: _____

Date: _____

FERRARA FAMILY
DENTISTRY

Dental Insurance Disclosure

We have prepared this letter to help you better understand the complexities of dental insurances; we realize how confusing they can be. To begin, we would like to highlight the common misconception that dental insurance was designed to pay for all care. It was not. Most contracts have limits and/or degrees of copayments.

All levels of payment by insurance companies, including allowed fees, usual and customary (UCR) are governed by the premiums paid. The have nothing to do with actual charges. Our fees are based upon a combination of our cost, our time, and our constant dedication to provide our patients with the highest quality of dental care. The treatment recommended by our office is never based on what your insurance company will pay. Your choices for treatment options will never be limited by your insurance contract.

Our office will file with your dental insurance company as a courtesy to you. However, it should be understood that the dental insurance contract is between the insurance company and the patient, who bears the ultimate financial responsibility. We will file your insurance for you as a courtesy. However, if for some reason your insurance company doesn't pay, after 60 days we will expect to have the costs for the procedure paid in full unless other arrangements are made beforehand. If your insurance hasn't paid after day 40, will will make every effort to contact you and your insurance company, and we will help you make your own insurance inquiry.

We hope this information has been helpful. Please take the time to review your contract thoroughly so we may best serve you. As always, feel free to ask any member of our staff for clarification on services, billing, and insurance.

Please sign here acknowledging your have reviewed and understand the information provided above. Thank you.

Name (Printed): _____

Signature: _____

Date: _____

301 Covington St. Madisonville, LA 70447 985-792-0515 www.ferraradental.com