HIGHLANDS FAMILY DENTISTRY
GENERAL, COSMETIC, AND IMPLANTS

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We would like to take the opportunity to welcome you and share some insights about what we do for our patients. Our purpose is to help people achieve the highest level of well-being appropriate for them and in so doing, to enhance the quality of their lives. In other words, we help you be or become as healthy as you choose. Instead of telling you how healthy you ought to be, we will try to help you understand your choices about dental health and then let you make a free and informed decision. Your first choice in this regard is how you would like to begin with us. There are five levels on which people may choose to be seen in our practice.

Please check the level of care you feel most appropriate for you at this time.

- ❑ Level 1...URGENT CARE
  - People in crisis or with an emergency problem such as pain, swelling or bleeding that need our immediate help are at this level.
- ❑ Level 2...REMEDIAL CARE
  - People who choose this level of care desire treatment only when something breaks or becomes uncomfortable. They usually want to correct immediate problems with as little effort and cost as possible.
- ❑ Level 3...SELF-CARE
  - Patients who choose this level of care want a thorough examination and take an active part in the treatment and prevention of present and future disease problems. However: they usually choose repair solutions that are short range in nature.
- ❑ Level 4...COMPLETE DENTISTRY
  - Patients at this level are similar to people described in level 3. They choose to have a thorough examination. However, they decide on a MASTER PLAN to formulate a long-term treatment plan for health and repair. These patients are very concerned about treating the causes of dental disease, not simply the effects. These patients want all dental treatment provided to be completed in the most lasting fashion as possible.
- ❑ Level 5...LOOK YOUR BEST
  - People in this group are in the level 4 as far as dental health is concern, but also want to look their best at all times. They know that their smile is the first thing others notice about them and want to put their best foot forward. They are willing to make the investment necessary for dental health.

We hope these levels make sense to you. It is not uncommon for people to begin at one level and progress to another over time. Thank you for the opportunity to let us serve you and provide you with the best dentistry appropriate for you.

Whom may we thank for referring you to us? _____

Patient Information

(Please Print)

Name _____ Date _____ Social Security Number _____
First MI Last

Email _____ Driver's License Number _____

Address _____ City _____ State _____ Zip _____

Birthdate _____ Home Phone # _____ Work Phone # _____

Cell Phone # _____ Do you prefer to receive calls at ❑ Home ❑ Work ❑ Cell ❑ Any

Are you: ❑ Minor ❑ Married ❑ Divorced ❑ Widowed ❑ Single ❑ Separated

You or your parent's employer _____ Occupation _____

Business Address _____ City _____ State _____ Zip _____

Spouse's or parent's name _____ Workplace _____ Work Phone # _____

If you are a student, name of school/college _____ City _____ State _____

Person to contact in case of an emergency _____ Phone # _____

Responsible Party

Name of person responsible for this account? _____

Relationship to patient _____ Phone # _____

Address _____ City _____ State _____ Zip _____

Name of employer _____ Work Phone # _____

Insurance Information

Name of insured _____ Relationship to patient _____

Birthdate _____ Social Security # _____ Date employed _____

Name of employer _____ Work Phone # _____

Address _____ City _____ State _____ Zip _____

Insurance Co _____ Group # _____ Employer # _____

Insurance Co Address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max annual benefit? _____

On a Scale of 1-10 – How would you rate your smile? _____

What would make it a "10"? _____

Do you want us to discuss this? _____

HEALTH HISTORY

Date of last health care exam _____ What was this exam for? _____

Have you been hospitalized in the last 5 years? ❑ No ❑ Yes

If yes, reason _____

Are you currently receiving care? ❑ No ❑ Yes If yes, nature of care _____

Please list all the names and phone numbers of the physicians who are currently providing you care:

1. _____
2. _____
3. _____
4. _____

For the following questions circle yes or no. Your answers are for our records only and will be confidential. Please not that during you initial visit you will be asked some questions about your response. Our team may ask additional questions concerning your health.

Heart Murmur (mitral valve prolapse)	❑ No	❑ Yes	Psychosis	❑ No	❑ Yes
Anemia	❑ No	❑ Yes	Sore/Enlarged Lymph Nodes	❑ No	❑ Yes
Diabetes	❑ No	❑ Yes	Previous Biopsies	❑ No	❑ Yes
Epilepsy	❑ No	❑ Yes	Slow- Healing Mouth Sores	❑ No	❑ Yes
Hepatitis, Any Form	❑ No	❑ Yes	Other Infections	❑ No	❑ Yes
Rheumatic Fever	❑ No	❑ Yes	Recurrent Illnesses	❑ No	❑ Yes
Asthma	❑ No	❑ Yes	Joint Replacement	❑ No	❑ Yes
HIV Positive or AIDS Related Complex	❑ No	❑ Yes	Glaucoma	❑ No	❑ Yes
Emphysema or other Respiratory Illnesses	❑ No	❑ Yes	Abnormal Bleeding from a cut	❑ No	❑ Yes
Abnormal Heart Condition	❑ No	❑ Yes	Liver Disease (including Jaundice)	❑ No	❑ Yes
Kidney	❑ No	❑ Yes	Unintentional Weight Loss/Gain	❑ No	❑ Yes
Heart (Surgery, Disease, Attack)	❑ No	❑ Yes	Latex Sensitivity	❑ No	❑ Yes
Venereal Disease	❑ No	❑ Yes	H.I.V. Infection/AIDS	❑ No	❑ Yes

One or more of the following symptoms may be indicative of Musculoskeletal Dysfunction of the head and neck. If you have any of the following symptoms, please indicate by circling the appropriate areas. (L = Left, R = Right)

Pain in the jaw joint	❑ L	❑ R	Pain in Tongue	❑ No	❑ Yes
Pain in ear	❑ L	❑ R	Loud Snoring	❑ No	❑ Yes
Pain around eyes	❑ L	❑ R	Mouth Breather at Night	❑ No	❑ Yes
Pain in lower jaw	❑ L	❑ R	Awaken with a Dry Mouth	❑ No	❑ Yes
Pain in upper jaw	❑ L	❑ R	Inability to Open Mouth	❑ No	❑ Yes
Pain in neck	❑ L	❑ R	Difficulty Swallowing	❑ No	❑ Yes
Pain in Shoulder	❑ L	❑ R	Constantly Tired	❑ No	❑ Yes
Pain in forehead	❑ L	❑ R	Dizziness (Vertigo)	❑ No	❑ Yes
Pain in temples	❑ L	❑ R	Difficulty Chewing	❑ No	❑ Yes
Pain in facial muscles	❑ L	❑ R	Facial muscle twitch	❑ L	❑ R
Clicking or popping sound in joint	❑ L	❑ R	Grating sound in joint	❑ L	❑ R
Ringing sound in ears	❑ L	❑ R	Fullness, pressure blockage in ears	❑ L	❑ R

Are you required to Pre- Medicate before dental treatment? ❑ No ❑ Yes

Women:	Are you Pregnant?	❑ No	❑ Yes
	If no, are you planning a pregnancy in the near future?	❑ No	❑ Yes
	Are you a nursing mother?	❑ No	❑ Yes
	Are you taking birth control pills?	❑ No	❑ Yes

Abnormal Blood Pressure? ❑ No ❑ Yes

If yes, what is it usually? S_____ /D_____

Are you allergic or have you had a reaction to:

a. Local anesthetics ❑ No ❑ Yes

b. Penicillin or other antibiotics ❑ No ❑ Yes

c. Aspirin ❑ No ❑ Yes

d. Codeine, Valium or other sedatives ❑ No ❑ Yes

e. Other_____

Are you a smoker? ❑ No ❑ Yes

If so, how much do you smoke per day?_____

What are your chief complaints? List from most to least important.

a. _____

b. _____

c. _____

Other symptoms (please write in) _____

_____

Please list any medications you are currently taking.

1. _____ 2. _____

3. _____ 4. _____

4. _____ 6. _____

FINANCIAL AGREEMENT

I, the patient/guardian, agree to be and hereby am fully responsible for total payment for procedures in this office. I understand that payment for dental services is due regardless of the benefits paid by my insurance company, and that if denied in part or in whole, payment in full becomes my responsibility. I understand that if I cancel or no show for an appointment with less than 24 hours notice, a fee will be charged. Any outstanding balance over 90 days will be turned over to a collection agency. At that time, I understand I will be responsible for the collection fee in the recovery of this debt.

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider of agency, who may release such information to you. I will notify the doctor of change in my health and medication.

_____ _____ _____

Patient (Print Name) Patient Signature Date

Thank you for your time!