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 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 *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? (*Check one:*) DAILY☐ / WEEKLY ☐ / OCCASIONALLY ☐

	Yes	**No**	**DK**
Are you currently experiencing dental pain or discomfort?	☐	☐	☐
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:

	Yes	**No**	**DK**
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?

	Yes	**No**	**DK**
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:

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Form S500

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* ( )			
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: ______

New Patient Information

We sincerely appreciate you choosing our office for your dental health care needs. Please be assured that we will work hard to continually earn the trust that you have placed in us. In order for us to serve you better, please take several minutes to complete this information form as thoroughly as possible.

Patient Information

Full Name: ____ Home Phone: ____________________________
Address: ____ Cell Phone: ______________________________
City: ____________________________________ State: _______ Zip: ___________ Date of Birth: ____ /____ /________ Sex: **M F**
Email Address: ____ Social Security #: ___________________________

Emergency Contact Name: ____

Emergency Contact Phone Number: ____________________________________

Who may we thank for referring you to us for care?

____

PREMEDICATION required? **Y N** If YES, what is the medication name: ____
Your Pharmacy name: ____ Pharm Phone #: __________________________

If the patient is a minor, please tell us about you, the responsible party (parent/guardian):

Your Name: ____

Relationship to Patient: _________________________

Your Date of Birth: _____ / _____ / __________ Sex: **M F**

Your Social Security #: __________________________

Your Address: ____ Contact Phone: __________________________________ City: ____________________________ State: ______ Zip: ____________ Email: ____

Dental Insurance Information

Name of Insurance Co: ____ Employer Name: ______________________________
Subscriber Name: ____

Plan Name: ___________________________________

Subscriber ID or SSN # ____

Group Number: ______________________________

Subscriber Date of Birth: _____ /_____ /________

Coverage Effective Date: _____ /_____ /________

Authorization and Signature on File

I, ____, certify that I, and/or my dependent(s) have insurance coverage with

____ Insurance Company Name(s)

I understand that **I am financially responsible for all charges** whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Dr. Gazaryan may use my healthcare information and may disclose such information to the above-named Insurance Company(s) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

No Show / Missed Appointment Policy

For your convenience, specific scheduled appointments are made at Heritage Dental to reserve time so that we can properly treat your dental needs. To provide this quality care, no one else is scheduled during your appointment time.
Due to today's high cost of maintaining a modern, sterile, completely staffed facility such as ours, we kindly request that you be present for the time reserved. Patients who choose to abuse their appointment time by not showing up will be charged, since operation expenses will continue in your absence. ***Please notify us 24 hours in advance if you need to change your appointment.*** Also notify us of any last-minute emergencies. This courtesy makes it possible to give your appointment time to another patient who needs to see the doctor. Our answering service is always available to take messages when the office is closed.

Appointment reminder calls and texts are made/attempted in days prior to your scheduled appointment. However, it is the responsibility of the patient to arrive for their appointment on time.

PLEASE REVIEW THE FOLLOWING POLICY:

1. Please cancel your appointment at least 24 hours before your appointment time.
2. If less than 24-hour cancellation is given this will be documented as a "NO-Show" appointment.
3. If you do not present to the office on time for your appointment, this will be documented as a "NO-Show" appointment.
4. NEW PATIENTS: If you have 2 "NO-Show/Missed" appointments within a one-year time period, you will no longer be allowed to schedule an appointment here at Heritage Dental.
5. EXISTING PATIENTS: If you have 3 "NO-Show/Missed" appointments within a one year time period, you will be dismissed from Heritage Dental.
   ***You will be notified by letter if the dismissal was approved**

I have read and understand Heritage Dental "NO-Show/Missed" appointments Policy and understand my responsibility to plan appointments accordingly and notify Heritage Dental staff appropriately if I have difficulty keeping my scheduled appointments.

____ (Patient/Parent/Guardian Name)

Signature: ______________________________ Date: ___________________

Agreement to Receive Electronic Communication

Patient Name: ______________________________________ Date of Birth: __________________

(Initial below)

I _____ DO AGREE

I______ DO NOT AGREE

That the Heritage Dental may communicate with me electronically at the email address and/or mobile phone number listed below.

Email: ______________________________________ Cell Phone: ___________________________

I am aware that there is some level of risk that third parties might be able to read unencrypted emails. I further agree that I am responsible for providing the dental practice any updates to my email address and/or mobile phone number.

My most preferred method of electronic communication:

(Initial below)

____Text Messaging

____ Email

I would like to receive:

____ Appointment Reminders/Recall Visits

____ Information regarding insurance/billing

____ Requests for Patient Satisfaction online reviews

I can withdraw my consent to electronic communications at any time by calling Heritage Dental at 609-646-3890 or email doctor@heritagedental.info

Patient Signature:______________________________________ Date:_______________________

5E Jimmie Leeds Road • Galloway, NJ 08205 • Phone (609)646-3890 • Fax (609)646-5151 • doctor@heritagedental.info

Financial Office Policies

All Fees including insurance deductibles, patient co-insurance and co-pay amounts must be paid at the time of service.

Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Our fees may be paid at the time of your visit as follows:

- ❖ We accept payments by Cash, Checks and Credit Cards (American Express, Discover, MasterCard, Visa).
- ❖ Senior citizens without dental insurance receive 5% discount on all services (does not apply to credit card payments)
- ❖ If your treatment plan requires several visits, we can split the overall cost into several payments on condition you pay in full by the end of treatment.
- ❖ Convenient monthly payment plans available from CareCredit (subject to credit approval). This allows you to pay for your dental and other health care needs over time with 0% interest, no annual fees or pre-payment penalties.

Please Note:

- ❖ $30 charge will apply for returned checks.
- ❖ Accounts that are over 90 days past due will be submitted to the Collection agency or filed with Atlantic County Small Courts.

For patients who have dental insurance - we are happy to work with your carrier to maximize your benefit and directly bill them for your treatment. You pay coinsurance and deductibles at the time of treatment.

DENTAL INSURANCE IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY TO PAY FOR A PART OF YOUR DENTAL CARE. SHOULD YOUR INSURANCE CARRIER REMIT LESSER AMOUNT THAN ESTIMATED OR DENY THE CLAIM PAYMENT FOR ANY REASON YOU ARE SOLELY RESPONSIBLE FOR THE UNPAID PORTION OF YOUR BILL OR FOR THE COST OF TOTAL TREATMENT.

Heritage Dental requires payment prior to completion of your treatment. If you pre-paid in full and choose to discontinue care before treatment is complete, any refund will be determined upon the review of your case.

I, ____ (Patient/Parent/Guardian Name) fully understand the financial policies of Heritage Dental and agree to them.

Signature: _________________________________ Date: ________________

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Patient Request for Treatment, Representation and Consent

Thank you for continued trust in our practice. As with transmission of any communicable disease like a cold or the flu, you need to understand that people may be exposed to COVID-19, also known as "Coronavirus", at any time or in any place.

Be assured that infection control has always been a top priority in our practice, and you may have seen this during your prior visits to our office. We follow recommendations and guidelines made by the American Dental Association (ADA), the Centers for Disease Control and Prevention (CDC), and the Occupational Safety and Health Administration (OSHA). **This allows us to make sure that our infection control procedures are up-to-date and enables us to provide the safest environment for our patients and their family members**.

Despite our attention to sterilization, disinfection, use of PPE and patient triage, there is still a chance that you could be exposed to an illness in our office, just as you might be at the grocery store, gym, restaurant, etc. Although we have taken measures to provide "social distancing" in our practice between the patients, due to the nature of procedures we provide it is not possible to maintain social distancing between you and Dr. Gazaryan, you and your hygienist, and sometimes other patients at all times.

Although exposure is unlikely, do you accept the risk and consent to all the procedures and the treatments recommended by Dr. Gazaryan at Heritage Dental?

YES _______ NO _______

____ (Initial) As a precondition to rendering treatment, I have confirmed in separate questionnaire that I have no symptoms commonly associated with COVID-19

____ (Initial) I confirm that I am not currently positive for the novel coronavirus.

____ (Initial) I confirm that I am not waiting for the results of a laboratory test for the novel coronavirus.

____ (Initial) I understand that individuals need to maintain social distancing of at least 6 feet, and it is not possible to maintain this distance and receive dental treatment.

____ (Initial) I verify that I have not been identified as a contact of someone who has tested positive for novel coronavirus or been asked to self-isolate.

____ (Initial) Even though we screen all our patients for respiratory infections, inadvertent treatment of a dental patient who is later confirmed to have COVID-19 may occur. To address this, we kindly request that you inform Heritage Dental if you develop symptoms or are diagnosed with COVID-19 within 14 days following your dental appointments.

Patient (Parent/Guardian) Name: ____

Signature: ________________________________ Date: __________________________

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Consent for Use and Disclosure of Health Information

Patient Name: ____

Patient Date of Birth: ____

Social Security #: ____

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your Protected Health Information, and other important matters about your PHI. A copy of our notice is available for your review at any time in the reception area. You may obtain a hard copy of the Notice from the front desk of our office any time at your convenience. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices. Those changes may apply to any of your protected health information that we maintain.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to Heritage Dental. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

Authorization and Signature

I, ____, have had full opportunity to read and consider the contents of this Consent Form and your Notice of Privacy Practices. I understand that, by signing this Consent Form, I am giving my consent to Heritage Dental to use and disclosure of my Protected Health Information to carry out treatment, payment activities and healthcare operations.

Patient Signature: ______________________ Date: __________

If this Consent is signed by a personal representative on behalf of the patient, please complete the following:

Legal Representative Name: ____

Relationship: ____

Legal Representative Signature: ______________________ Date: ______________

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