Williams & Pearce Family Dental

HEALTH HISTORY

Minor Form

Date_____ Patient Name_____ Name child wishes to be called_____
Physical Address_____HomePhone_____
City_____State_____Zip Code_____Work Phone_____
Mailing Address_____City_____State_____Zip Code_____Cell Phone_____
Email Address:_____Best Time and Place to be reached_____
Sex: ☐Male ☐Female Age_____Birthdate_____ Patient SS# _____
Parent name_____ Birthdate_____ SS#_____
Occupation_____ Employer Name & Phone #_____
Parent name_____ Birthdate_____ SS#_____
Occupation_____ Employer Name & Phone #_____

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IN CASE OF EMERGENCY PLEASE CONTACT (Someone not living with you)
Name_____Relationship to you_____
Address and Phone Number of Emergency Contact Person_____

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Whom may we thank for referring you?_____

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Who is responsible for this account?_____Relationship to patient_____
Insurance Company_____Group #_____
Subscriber's name_____Subscriber's ID#_____
Subscriber's Birthdate_____ Relationship to Patient_____ Is patient covered by additional Insurance? ☐Yes ☐No
Insurance Company_____Group#_____

ASSIGNMENT AND RELEASE I, the undersigned certify that I (or my dependent) have insurance coverage with ***the above insurance company*** and assign directly to doctor otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Patient portion due at appointment.

DIVORCE: In case of divorce or separation, the parent accompanying the child and authorizing treatment will be the parent responsible for the charges on the day of service. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

_____ _____ _____
Responsible Party Signature Relationship Date

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DENTAL HISTORY

Reason for today's visit_____
Former Dentist_____City/State_____
Date of last dental visit_____Date of last dental X-rays_____

Bad Breath	☐Yes ☐No	Blisters on lips or mouth	☐Yes ☐No
Burning sensation on tongue	☐Yes ☐No	Cigarette/Pipe/Cigar smoking	☐Yes ☐No
Clicking/popping jaw	☐Yes ☐No	*Have you ever attempted to quit?*	☐Yes ☐No
Pain/Discomfort in jaw joint	☐Yes ☐No	Chewing Tobacco	☐Yes ☐No
Periodontal Disease	☐Yes ☐No	*Have you ever attempted to quit?*	☐Yes ☐No
Loose teeth or broken fillings	☐Yes ☐No	Fingernail Biting	☐Yes ☐No
Pain around ear	☐Yes ☐No	Grinding Teeth	☐Yes ☐No
Sores or growths in mouth	☐Yes ☐No	Lip or cheek biting	☐Yes ☐No
Sensitivity to	☐Yes ☐No	Orthodontic treatment (*Braces*)	☐Yes ☐No
☐*Heat* ☐*Cold* ☐*Sweets* ☐*Biting*	☐Yes ☐No	Gums Swollen	☐Yes ☐No
Bleeding Gums	☐Yes ☐No	Do you like your smile	☐Yes ☐No
Dry Mouth	☐Yes ☐No	Have you ever had a serious/difficult	
Mouth Breathing	☐Yes ☐No	problem associated with dental work?	☐Yes ☐No
How often do you floss?_____		Do you drink fluorinated water or take	
How often do you brush?_____		fluoride supplements?	☐Yes ☐No
Type of bristles: ☐*Hard* ☐*Medium* ☐*Soft*			

Primary Care Physician's Name:_____ Date of last visit:_____

Specialist's Name *(Cardiac, Orthopedic, Oncologist, Etc.)*:_____ Date of last visit:_____

Please check Yes or No to indicate if you have had any of the following:

AIDS/HIV Positive ☐Yes ☐No
Anemia ☐Yes ☐No
Arthritis, Rheumatism ☐Yes ☐No
Asthma ☐Yes ☐No
Back Problems ☐Yes ☐No
Bleeding Abnormal ☐Yes ☐No
Tuberculosis ☐Yes ☐No
Blood Disease ☐Yes ☐No
Cancer: Type_____ ☐Yes ☐No
Chemotherapy ☐Yes ☐No
Radiation Treatment ☐Yes ☐No
Chemical Dependency ☐Yes ☐No
Circulatory Problems ☐Yes ☐No
Cortisone Treatments ☐Yes ☐No
Cough, Persistent/bloody ☐Yes ☐No
Diabetes: Type:_____ ☐Yes ☐No
☐*Pills* ☐*Injection* ☐*Pump*
Epilepsy ☐Yes ☐No
Fainting or Dizziness ☐Yes ☐No
Glaucoma ☐Yes ☐No
Organ Transplant ☐Yes ☐No
*Year:*_____ *Type:*_____

Headaches ☐Yes ☐No
Heart Problems: ☐Yes ☐No
*Type:*_____
Congenital Heart Lesions ☐Yes ☐No
Heart Murmur ☐Yes ☐No
Mitral Valve Prolapse ☐Yes ☐No
Pacemaker ☐Yes ☐No
Heart Attack: ☐Yes ☐No
*Date:*_____
High / Low Blood Pressure ☐Yes ☐No
*Meds:*_____
Hepatitis: ☐Yes ☐No
*Type*_____
Oral Herpes ☐Yes ☐No
Jaundice ☐Yes ☐No
Jaw Pain ☐Yes ☐No
Joint Replacement ☐Yes ☐No
*Year:*_____ *Type:*_____

Kidney Disease ☐Yes ☐No
Liver Disease ☐Yes ☐No
Nervous Problems ☐Yes ☐No
Psychiatric Care ☐Yes ☐No
Respiratory Disease ☐Yes ☐No
Shortness Of Breath ☐Yes ☐No
Sinus Trouble ☐Yes ☐No
Skin Rash ☐Yes ☐No
Special Diet ☐Yes ☐No
Stroke: *Year*_____ ☐Yes ☐No
Swelling Of Feet Or Ankles ☐Yes ☐No
Swollen Neck Glands ☐Yes ☐No
Thyroid Problems ☐Yes ☐No
Ulcer ☐Yes ☐No
Tumor/Growth On Head Or Neck ☐Yes ☐No
Venereal Disease ☐Yes ☐No
Any Hosiptal Stays ☐Yes ☐No
*Explain:*_____
Other Conditions Not Listed:
_____
_____
_____

Women: Are your pregnant? ☐**Yes** ☐**No** * Due Date:_____
Are you nursing: ☐**Yes** ☐**No** * Are you taking birth control pills? ☐**Yes** ☐**No**

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MEDICATIONS

Please list medications you are currently taking:

_____
_____
_____

Pharmacy Name_____

ALLERGIES

☐ No Known Allergy
☐ Aspirin
☐ Barbiturates (sleeping pills)
☐ Codeine
☐ Local Anesthetic
☐ Latex
☐ Iodine
☐ Penicillin
☐ Sulfa
☐ Other _____

I understand I am responsible for my account balance regardless of my insurance. I also understand that my insurance is an agreement between my insurance company and myself. WP Dental will prepare and submit necessary forms to help you obtain your benefits.

I understand that I may be charged a 1% finance charge per month (12% annually) if my balance goes beyond 60 days from date of service not from date the insurance company pays my benefits. ***Patient portion due at appointment.***

I give permission for my dentist and clinical team to take any necessary radiographs, study models, and photographs to make a complete diagnosis of my dental needs. I also give permission for my dentist and dental team to use my photographs for in-office patient education.

I consent to the use and disclosure of my protected health information to obtain payment information in connection with my dental claims.

_____ _____

Responsible Party Signature Date

(I have read, agree to, and understand the statements listed above.)