ToothHQ™
Dental Specialists
The Smile Headquarters

Dental Implants | Periodontics | Oral Surgery
smile@mytoothhq.com | www.MyToothHQ.com
Tel: 214.731.0123 | Fax: 214.731.1122
DALLAS | CARROLLTON | GRAPEVINE | CEDAR HILL

PATIENT INFORMATION AND HEALTH HISTORY FORM

❍ Mr. ❍ Mrs. ❍ Ms. ❍ Dr. Sex: ❍ Male ❍ Female Nick Name (if any)_____
First Name_____ M.I._____ Last Name_____
Date of Birth _____ Age_____ SSN_____ DL# & State_____
Street _____ City _____ State _____ Zip_____
Home # _____ Cell # _____ Does your cell accept text messages? ❍ Yes ❍ No
E-mail _____
Work # _____ x _____ Employer _____
Family, relative or friend to be notified in case of emergency:
Name _____ Relation_____ Cell # _____

Purpose of Your Visit - Your Risk Awareness - Your Oral Health Status

What dental/oral issue brought you to our office today? (explain) _____

❑ Yes ❑ No Have you ever been made aware of the health problems connected to gum disease and dental/oral bacterial infections that may cause heart attack, stroke, diabetic issues, brain damage and so on?

What would you like to accomplish today? (explain)_____
❑ Get out of pain ❑ Improve my smile ❑ Keep my teeth ❑ Eliminate infection ❑ Improve self-confidence ❑ Chew better

On a scale of 1 - 10 with 10 being the best, how important is your dental/oral health to you?_____
On a scale of 1 - 10 with 10 being the best, where do you feel your dental/oral health is currently?_____

If your dental/oral health score is not 9 or above, what is stopping you from achieving your goal (e.g., time, fear, lack of awareness)? _____

Other dental visit related information (check all that apply):
❑ Bad dental experience in the past ❑ Fear of dentist treatment ❑ Fear of pain ❑ Unable to eat well
❑ Unhappy with dental appearance or smile ❑ Unhappy with dentures or flipper/partial
Date of last cleaning? _____ Frequency of cleaning?_____
Date of last deep cleaning? _____ Frequency of deep cleaning if had more than once?_____
❑ I am interested in getting the work done today, if your office schedule allows

If you had a magic wand, what, if anything, would you change about your smile/oral health? (check all that apply):
❑ Keep my teeth longer ❑ Prevent huge expenses for dental work ❑ Permanent teeth replacement ❑ Prevent bone loss
❑ Get rid of/Fix my dentures ❑ Stop bleeding from gums ❑ Stop tooth loss ❑ Other (mention)_____

Just a little bit about ME!

My fav (favorite) sports & team: Sports (mention) _____ Team (mention)_____
Fav thing I do in my spare time (check all that apply): ❑ Movies ❑ Music ❑ Internet ❑ Other (mention)_____
My fav place to shop _____ My fav food & restaurant _____
My fav fast food restaurant_____ My fav non-profit org (if any)_____
My fav gifts (check all that apply): ❑ Purse ❑ Perfume ❑ Watch ❑ Gadget (mention) _____
❑ Other (mention) _____
Gift cards I like (check all that apply): ❑ Starbucks ❑ Target ❑ Walmart ❑ Amazon ❑ Kohl's ❑ Macy's ❑ Best Buy
❑ Home Depot ❑ Other (mention) _____
Languages I speak (other than English) _____ I grew up in (place) _____
Countries I have visited_____ Best place I travelled recently _____

Who may we thank for referring you to our office? (Referral Resource)

❑ Dentist Name_____ Phone _____ City _____ How long? _____
❑ Orthodontist Name _____ Phone _____ City _____ How long? _____
❑ Physician Name _____ Phone _____ City _____
❑ Friend/Family Name _____ ❑ Drive by/Street Sign ❑ Internet (Source) _____

❑ Google ❑ Yahoo ❑ Bing ❑ Ask.com ❑ ZocDoc ❑ Facebook ❑ Twitter ❑ Yelp ❑ Dr. Oogle
❑ Healthgrades.com ❑ Ratemds.com ❑ Vitals.com ❑ Other (Source)
Search term used while doing the search online:_____
I have a user account with (check all that apply): ❑ Yelp ❑ Angie's List ❑ Gmail
❑ Flyer ❑ Brochure ❑ Business Card I picked up your office Flyer/Brochure/Business Card from (location name):
❑ Dentist_____ ❑ Physician _____ ❑ Other (mention) _____

Pay it forward... Who can you help/refer? Wellness moral support groups help people live longer.

Who may need your help with a referral to a free dental consultation?
Name, Cell #, & Email 1) _____
Name, Cell #, & Email 2) _____
Name, Cell #, & Email 3) _____
Name, Cell #, & Email 4) _____
Name, Cell #, & Email 5) _____

Responsible adult for this account

Who is responsible for this account? ❍ Self ❍ Other If other, please fill out below:
Responsible party's name: _____ Relation: ❍ Spouse ❍ Father ❍ Mother ❍ Other
SSN _____ Date of Birth_____ Age_____ DL# _____
Home # _____ Work #_____ x _____ Cell # _____
Address (if different from above) _____
City _____ State _____ Zip _____ Employer _____

Primary Dental and/or Medical Insurance (Provide Policy Holder's Information Only)

Name of Policy Holder _____ Relation _____
Sex: ❍ Male ❍ Female Date of Birth _____ SSN _____
Address (if different from above) _____
City _____ State _____ Zip_____
Home # _____ Work #_____ x _____ Cell # _____
Insurance Company Name_____ Insurance Phone # _____
ID# _____ Group/Employer Name _____

List of Medical Conditions

Check all of the following conditions that you may have had in the past or that currently apply to you:

❑ Heart attack _____
❑ Chest pain upon exertion
❑ Shortness of breath
❑ High blood pressure
❑ Low blood pressure
❑ Transient ischemic attack
❑ Stroke
❑ Heart valve prosthesis
❑ Mitral valve prolapse
❑ Congenital heart lesion
❑ Rheumatic fever
❑ Heart murmur
❑ Damaged heart valve
❑ Irregular heartbeat
❑ Tachycardia
❑ Heart surgery
❑ Cardiac pacemaker
❑ Lupus Erythematosus/SLE

❑ Knee replacement_____
❑ Hip replacement _____
❑ Hepatitis ❑ A ❑ B ❑ C
❑ HIV / AIDS
❑ Received blood transfusion
❑ Liver disease or Jaundice
❑ Gallbladder disease
❑ Anemia / Leukemia
❑ Bleeding disorder
❑ Bruise easily
❑ Hemophilia
❑ Kidney disease
❑ Active dialysis
❑ Impaired kidney function
❑ Esophageal reflux
❑ Hiatal hernia
❑ Stomach ulcer
❑ Anorexia or bulimia

❑ Irritable bowel syndrome
❑ Colitis
❑ Bladder problems
❑ Diabetes
❑ Insulin dep. diabetes
❑ Uncontrolled diabetes
❑ Low blood sugar
❑ Radiation therapy
❑ Chemotherapy
❑ History of cancer
❑ Sleep apnea
❑ Use sleep apnea device
❑ Asthma
❑ Bronchitis
❑ Emphysema
❑ Sinus disease
❑ Coughing up blood
❑ Tuberculosis

❑ Pneumonia
❑ Arthritis
❑ Connective tissue disorder
❑ Neurological disorders
❑ Ringing in ears
❑ ChronicHeadache / Migraines
❑ Epilepsy / Seizures _____
❑ Mental health problems
❑ Chronic fatigue
❑ Recent weight loss / gain
❑ Glaucoma
❑ Wear contact lenses
❑ Blurred / impaired vision
❑ High cholesterol
❑ Thyroid condition
❑ Cancer, tumor or growths

If you have checked any of the above or have any disease, problem or condition not listed above, please explain: _____
_____
_____

Medical Health History

Current Physician (if any): Name _____

Phone # _____ City _____ How long _____

❍ Yes ❍ No Are you in good health? Last Physical Date _____ Height _____ Weight _____

❍ Yes ❍ No Have you recently been treated for any illness by your physician? Date of last visit: _____
If so, for what are you being treated? _____

❍ Yes ❍ No Have you had any serious illness, operation or been hospitalized in the past five years?
If so, describe: _____

❍ Yes ❍ No Do you have unhealed/recurrent injuries or inflamed areas, growths or sore spots in or around your mouth?
If so, describe: _____

❍ Yes ❍ No Do you have a prosthetic joint or other metal implant? If so, explain: _____ Year: _____

❍ Yes ❍ No Have you had a heart (cardiac) stent? If so, when? _____

❍ Yes ❍ No Have you had a pacemaker? If so, when? _____

❍ Yes ❍ No Have you had a heart valve replacement or vascular graft? If so, when? _____

❍ Yes ❍ No Has your cardiologist, physician or dentist ever told you to take antibiotics prior to having any type of dental procedure, for any **heart related disease or condition (such as leaky/damaged heart valve)**?

❍ Yes ❍ No Has your orthopedic surgeon, physician or dentist ever told you to take antibiotics prior to having any type of dental procedure, for any **orthopedic related disease or condition (such as total hip/knee replacement)**?

❍ Yes ❍ No **Are you currently taking any blood thinning medications (e.g., Aspirin)?** If so, what, how much, and how long? _____
_____

❍ Yes ❍ No Has your dentist ever told you to take antibiotics prior to having any type of dental procedure, routinely?
If so, for what condition or disease (explain)? _____

❍ Yes ❍ No Do you smoke? If so, how much? _____ ❍ per day ❍ week ❍ month

❍ Yes ❍ No Do you use smokeless tobacco? If so, what form? _____
How much? _____ ❍ per day ❍ week ❍ month

❍ Yes ❍ No Have you ever used tobacco in the past? If so, how much? _____ ❍ per day ❍ week ❍ month
Quit date: Month _____ Year _____

❍ Yes ❍ No Do you drink alcohol? ❍ Regularly ❍ Occasionally
If so, how much? _____ ❍ per day ❍ week ❍ month

❍ Yes ❍ No Do you have any history of alcohol abuse? If so, explain: _____

❍ Yes ❍ No Do you have any history of substance abuse or do you currently use recreational drugs?
Describe form, use or abuse history: _____

❍ Yes ❍ No Have you ever taken, or are you currently taking any other of the following drugs orally (check all that apply)?
❑ Fen-Phen diet pills ❑ Other diet pills (explain): _____

❍ Yes ❍ No Is there a family history of: ❑ Cancer ❑ Diabetes ❑ Heart disease ❑ Anesthesia problems

❍ Yes ❍ No Have you ever had radiation therapy to the head and neck area?
When? _____ What type of cancer? _____

❍ Yes ❍ No Have you ever had chemotherapy treatment of any type of cancer?
When? _____ What type of cancer? _____

❍ Yes ❍ No Did your cancer spread to the bone and were you treated for this bone spread (metastasis)? If so, explain: _____
_____

For any **bone related disease or condition, have you ever been administered, or are you currently taking any of the following drugs** (check all that apply):

❑ I was given this drug to treat: ❑ osteoporosis / osteopenia ❑ another bone problem
❑ I was given this drug during cancer chemotherapy to treat bone cancer or spread of my cancer to bone.

Administration route: ❑ Oral Pills ❑ Intravenous (IV) ❑ Intramuscular (IM)

❑ Alendronate (Fosamax)	❑ Risedronate (Actonel)	❑ Ibandronate (Boniva)	❑ Pamidronate (Aredia)
❑ Zometa (Zolendronate)	❑ Reclast (Zolendronate)	❑ Xgeva (Denosumab)	❑ Prolia (Denosumab)
❑ Didronel	❑ Bonefos	❑ Skelid	❑ Oral/IV Bisphosphonates
❑ Sunitinib (Sutent)	❑ Sorafenib (Nexavar)	❑ Bevacizumab (Avastin)	❑ Sirolimus (Rapamune)

Oncologist (if any): Name _____ Phone# _____ City _____ How long? _____

WOMEN NOTE (check all that are apply): ❑ I am taking Birth Control Pills (BCP) ❑ I am pregnant ❑ I am nursing
Some medications (e.g., penicillin) may alter the effectiveness of BCP. Consult your physician for assistance regarding alternate methods of birth control. By signing this form, I agree to inform the office about my pregnancy status prior to x-rays being performed.

List medications you are currently taking with the reason / Allergies to Medications

Name of Medicine, Herbal Medicine, Over the counter Medicine, Vitamin or Street Drug	Dosage (mg/mcg/ml)	How often is it taken	Disease Being Treated or Reason for Taking	Prescribed by Doctor or Self-Prescribed
				❍ Doctor ❍ Self
				❍ Doctor ❍ Self
				❍ Doctor ❍ Self
				❍ Doctor ❍ Self
				❍ Doctor ❍ Self
				❍ Doctor ❍ Self
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				❍ Doctor ❍ Self
				❍ Doctor ❍ Self
				❍ Doctor ❍ Self

Check any of the following medications you are allergic to:

❑ Penicillin	❑ Tetracycline	❑ Demerol	❑ Versed	❑ Tylenol	❑ Advil
❑ Erythromycin	❑ Sulfa Drugs	❑ Vicodin	❑ Halcion	❑ Ibuprofen	❑ Dental Anesthetics
❑ Keflex	❑ Codeine	❑ Lortab	❑ Valium	❑ Acetaminophen	❑ Latex
❑ Doxycycline	❑ Hydrocodone	❑ Darvocet	❑ Aspirin	❑ Aleve	❑ Iodine

Any others? _____

Fees and Payments

At ToothHQ, your oral health, overall health and the cost of your oral healthcare is very important to us. Financial arrangements can be made with our office for any treatment rendered. If you have any dental and/or medical insurance, we will be glad to fill out the proper forms, for appropriate reimbursement. Please remember that dental or medical insurance is a form of benefit and is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. ToothHQ will make every effort to estimate the benefits from your insurance carrier. However, it is your ultimate responsibility to pay the deductible amount, co-insurance, estimated benefit not paid by your insurance carrier, or any other balance on your account. You will be responsible for all collection agency costs, attorney fees, court costs, miscellaneous administrative and processing fees. I hereby authorize payment to ToothHQ of any insurance benefits otherwise payable to me. I hereby understand a fee of $45.00 (Forty-five Dollars), or the maximum amount allowed by law, will be assessed for each returned check. ToothHQ reserves the right to reschedule, cancel, shorten, or lengthen an already scheduled appointment, and collect any non-refundable deposit as required. I acknowledge to have received information for my same-day procedure appointment requiring a deposit fee of up to $250 (Two hundred and fifty Dollars) and I hereby agree to pay this amount to secure my appointment that will be applied as a credit to my account. All appointments require a minimum of 48 hours prior to the appointment for cancellation or rescheduling to avoid the cancellation or rescheduling fee that may vary up to a maximum of $250 and ToothHQ reserves the right to apply this charge to your account whether you are a new patient or an established patient. ToothHQ reserves the right to apply a finance charges as applicable, or the maximum amount allowed by law, to all account balances after 90 days as allowed by state law. All services should be paid in full at the time of service, if the patient or the guarantor declines to provide identity information such as copy of driver's license or social security number.

Authorization and Consent

I hereby give my consent for ToothHQ to use, share and disclose Protected Health Information (PHI) about me to carry out Treatment, Payment & healthcare, Operations (TPO) as regulated by the Health Insurance Portability and Accountability Act (HIPAA). The PHI includes information that is created and received by the practice and may be in written, electronic or spoken form. The HIPAA Notice of Privacy Practices (NoPP) maintained by ToothHQ describes such uses and disclosures more completely. I have the right to review the NoPP prior to signing this consent. ToothHQ reserves the right to revise its NoPP at any time. A revised NoPP may be obtained by forwarding a written request to ToothHQ. With this consent, ToothHQ may contact my home or other designated location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others. I understand ToothHQ's communication modalities may include mail, phone calls, emails, or text messages. I also understand any communication modalities include risks such as wrong delivery, stealing, hacking, monitoring, interception, alteration, and so on. I agree and understand the risks associated with these type of communications. By signing this authorization, I confirm that it accurately reflects my wish to receive health information by the means above, and I will not hold ToothHQ liable for any unintentional disclosure of my health information or any costs I may incur that is associated with the sending or reception of any of these types of communications. I have the right to request that ToothHQ restrict how it uses or discloses my PHI to carry out TPO. I understand that I have the right to terminate or revoke this authorization by submitting a written revocation to ToothHQ at any time. ToothHQ may not be required to agree to my requested restrictions and may explain so. By signing this form, I am consenting to allow ToothHQ to use and disclose my PHI to carry out TPO as explained here as well as the NoPP. I also acknowledge that a copy of ToothHQ's Notice of Privacy Practices has been made available to me. I agree and understand, ToothHQ will not be liable, regardless of the form of action or theory of recovery, for any direct, indirect, incidental, consequential, special, punitive or exemplary damages in connection with, or in any way related to this Authorization or ToothHQ's use of these types of communications authorized here.

I hereby authorize and consent for doctors and staff at ToothHQ to perform an oral exam for the purpose of diagnosis and treatment planning. Furthermore, I authorize the taking of all x-rays, CT Scans, or photographs, testimonials, videos, filming, recording (collectively knows as "items") required as a necessary part of this exam, ongoing care, research and development (R&D), or any form of promotion of patient care and practice. I understand these items as well as patient care documents, may be used for R&D, educational purposes in lectures, demonstrations, advertising and promotion, and professional publications. If any of these items are part of the clinical care, recommended to you, but declined by you, we may make a note of that in your chart that releases ToothHQ or the treating doctor from any liability related to your examination or treatment. In addition, if medically necessary, I authorize the release of any information acquired in the course of my exam and treatment. I understand that this form cannot be altered or modified in any manner except in writing and subscribed by both the patient and an authorized ToothHQ employee. Additionally, I agree that in the event that a waiver for any breach of any term or condition hereunder shall not constitute a waiver of any further term or condition. If any one or more of the provisions contained in this Agreement shall for any reason be held to be invalid, illegal or unenforceable in any respect by any agency or a judicial body, such holding shall not affect the validity and enforceability of any other provisions hereof. We have the right to deny treatment to anyone, if we feel this form is incomplete and contains inaccurate or conflicting information to the documentations (such as driver's license or insurance card) provided. I will not hold any ToothHQ doctors or staff responsible for any errors or omissions that I have made in the completion of this form. If I am a female patient and if applicable, I further agree to inform the x-ray taking personnel and the treating doctor about my pregnancy status prior to any x-ray procedure being performed, I understand my rights to deny or accept any x-ray procedure being recommended if I am currently pregnant, and I will not hold any ToothHQ doctors or staff responsible for any consequences if I did consent to have the x-ray procedure, while I am, was, or may have been pregnant. I, as the patient or the guardian of patient who is a minor, agree to the terms, conditions, statement and policies as stated in this form while becoming a patient or patient's guarantor at ToothHQ. I certify that I have received counsel regarding any questions related to this form, fully understand, acknowledge and accept the above information, and am in agreement by my signature below.

_____ _____

Signature of Patient (Parent or guardian if minor) **Date**

Doctor review / notes:

Dr. Name: _____ **Dr. Signature:** _____