GRUENE FAMILY DENTAL
KIM TURNBOW, D.D.S.

Health History, Office Policies and Insurance Information Form

Please complete this form to the best of your knowledge and bring it with you PRIOR TO YOUR APPOINTMENT. Please print legibly, your answers are for our records only and will be kept confidential subject to applicable laws.

GENERAL INFORMATION:

Name: _____ Preferred Name if different: _____
Address: _____ City: _____ Zip: _____
Cell Phone: _____ Home Phone: _____ Work: _____
Email Address: _____ May we text and email you? ☐ Yes ☐ No
Birth date: _____ SS#:_____ Occupation: _____ Male ☐ Female ☐
Emergency Contact Name: _____ Cell Phone: _____
How did you hear about our office? _____

PERSON RESPONSIBLE FOR ACCOUNT: (If other than the patient)

Name: _____ Relationship to Patient: _____
Address: _____ City: _____ Zip: _____
Cell Phone: _____ email: _____

DENTAL INSURANCE INFORMATION:

Policy Holder's Name: _____ Date of Birth: _____
Policy Holder's ID Number: _____ Policy Holder's Employer: _____
Dental Insurance Company: _____ Dental Insurance Phone: _____
Additional insurance information: _____

INSURANCE ESTIMATES AND BILLING

Estimates for dental treatment are valid for 30 days. Payment is due at time of treatment unless other arrangements have been made PRIOR TO YOUR APPOINTMENT. For patients with insurance plans, **we cannot guarantee your coverage, we will provide an estimate**. The patient is responsible for any charges not covered by insurance, and will pay at the time of service. We reserve the right to charge interest in the amount of 18% per annum as provided by state law. All accounts aged past 90 days WILL BE SENT to an outside collection agency.

I hereby authorize payment directly to the dental practice listed above of the dental benefits otherwise payable to me. I understand my signature is valid unless revoked by me. Gruene Family Dental and staff are authorized to provide any insurance company(s), claim administrator(s) and consulting healthcare professionals, information concerning healthcare advice, treatment or supplies provided. This information will be used for the purpose of evaluating or administering claims for benefits. This authorization is valid for the term of coverage of the policy or contract. I know I have the right to receive a copy of this authorization upon request.

_____ _____
Signature Date

DENTAL HEALTH INFORMATION:

Reason for today's visit:

_____

_____

When was your last visit?

_____

Are you in pain? If yes, please describe:

_____

How do you feel about your smile? _____

Is there anything you would like to change about your smile?

_____

Have you ever had to take Antibiotics prior to dental work? _____NO _____YES

REASON WHY: _____

Physician or Dentist who prescribed them:

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

	Yes	No
Bad taste		
Bad breath		
Bleeding gums		
Blisters on lips/mouth or Ulcers		
Chew only on one side		
Tobacco use		
Clicking/popping of jaw		
Dark teeth		
Dry mouth		
Oral habits (fingernail biting)		
Food collecting between teeth		
Grinding/Clenching teeth		
Gums swollen/tender		
Apprehensive about treatment		

	Yes	No
Fever Blisters		
Jaw pain/tiredness		
Lip/cheek biting		
Loose teeth		
Broken fillings		
Mouth breathing		
Orthodontic treatment		
Dentures or Partials		
Sensitivity to cold/hot/sweets		
Biting sensitivity		
Sores or growths in your mouth		
Unhappy with your smile		
Ear ache/neck pain		
Crowding of teeth		

MEDICAL HISTORY AND INFORMATION:

General Physician: _____ Phone: _____ Date of last medical exam: _____

Have there been any changes in your general health in the last year? ___Yes ___No If yes, what conditions are being treated?

_____

Please list Past Operations, Medical Procedures, Serious Illness, or past hospitalizations:

_____

Please list all medications, including over the counter medicines, herbal supplements/vitamins, recreational drugs or alcohol:

ALLERGIES: Are you allergic to or have you had a reaction to the following

Please indicate "Yes" or "No"

	Yes	No
Local anesthetics		
Aspirin		
Penicillin		
Metal		
Iodine		
Food		

	Yes	No
Sulfa drugs		
Barbiturates, sedatives or sleeping pills		
Codeine or other narcotics		
Latex		
Hay Fever or Seasonal allergies		
Other:		

FEMALE PATIENTS: Please indicate "Yes" or "No"

	Yes	No
Are you pregnant		
Breastfeeding		
Trying to get pregnant		
Taking Birth Control		

If Pregnant, how many weeks? _____

Name of OBGYN: _____

Office Phone or Fax: _____

JOINT REPLACMENT:

Have you had an orthopedic total joint replacement? ____Yes ___No

List the joint (s) that was (were) replaced: _____

Date: _____ Any Complications: _____

Surgeon: _____ Phone: _____

Were you told to take Antibiotics prior to dental care? ___Yes ___No

If yes, for how long? _____

HEART SURGERY OR CONGENITAL DEFECTS: Please mark one

	Yes	No
Artificial (Prosthetic) heart Valve		
Previous Infective Endocarditis		
Damaged valves in heart transplant		

	Yes	No
Unrepaired, cyanotic CHD		
Repaired within last 6 months		
Repaired with residual defects		

BISPHOSPHONATES: Please indicated "Yes" or "No" to the following questions	Yes	No
Are you taking or scheduled to take either of the medications, Alendronate (Fosamax) or Risedronate (Actonel) for OSTEOPORSIS or PAGET'S DISEASE?		
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia or Zometa) for bone pain, Hypercalcemia skeletal complications resulting from Paget's disease, Multiple Myeloma, or Metastatic Cancer?		
Date to begin treatment? Name of Physician starting treatment: _____ Phone: _____		

Please mark "Yes" or "No" if you have or have ever had any of the following conditions.

	Yes	No			Yes	No			Yes	No
Cardiovascular Disease				Anemia/Sickle Cell Anemia				Cancer/Chemotherapy/Radiation		
Angina/Chest Pain on exertion				Blood Transfusion (when:___)				Chronic Pain		
Arteriosclerosis				Hemophilia				Diabetes Type I or II		
Congestive Heart Failure				AIDS or HIV Infection				Family History of Diabetes		
Stroke/TIA				Osteoporosis				Recurrent Infections		
Damaged Heart Valve				Arthritis/ Rheumatoid Arthritis				Gastrointestinal Disease		
Heart Attack				Autoimmune Disease				GERD/Reflux/Heartburn		
Heart Murmur				Back Problems				G.I. Ulcers		
Low Blood Pressure				Lupus				Thyroid Problems (low or high)		
High Blood Pressure				Asthma				Kidney/Bladder Disease		
Congenital Heart Defects				Bronchitis				Dialysis		
Mitral Valve Prolapse				Emphysema				Hepatitis (type: __) or Jaundice		
Pacemaker				COPD				Epilepsy		
Rheumatic Fever/Heart Disease				Sinus Trouble				Fainting Spells/ Dizziness		
Abnormal Bleeding				Tuberculosis				Seizures		
Hearing Problem				Mental Health Disorder				Sleep Disorder		
Vision Problems				Neurological Disorder				Wear a CPAP		
Glaucoma				Psychiatric Treatment				Drug use (illegal)		
Swollen Glands in Neck				Depression				Alcohol Use		
Shingles				Migraines				STD		
Gout				Anxiety				Herpes		
HPV (when diagnosed:_____)				Family History of Cancer						

Please list any additional Medical or Health Problems not listed on this form:

_____

_____

CANCELLATION, MISSED OR BROKEN APPOINTMENT POLICY

Appointments are confirmed with email, text and phone calls starting two weeks prior to your dedicated appointment time. However emergencies do arise and we will accommodate your schedule as best we can. If you must change your appointment we **require at least 48 hours notice to avoid the missed appointment fee starting at 35.00**.

RETURNED CHECK FEE

A $50.00 returned check fee will be charged for all returned checks, and no future checks will be accepted.

GENERAL CONSENT FOR TREATMENT

I have completed this form to the best of my knowledge and all the information is accurate and current.

I give permission to Gruene Family Dental to take any necessary diagnostic x-rays, photos, tests, and/or study models required to enable complete diagnosis and treatment. I consent to treatment as necessary or desirable for myself, or the patient named above.

I am aware that Gruene Family Dental may contact me by phone, email or text and they have my permission to send messages or leave voicemails for me regarding my appointments, treatment or payments.

I authorize the release of information to other medical or dental providers, including laboratories, when necessary for treatment.

_____ _____

Signature Patient or Guardian **Date**

_____ _____

Doctor **Date**