

MEDICAL HISTORY

Name: _____ () M () F Date of Birth: _____

Address: _____ City, State, Zip: _____

Contact: Home Phone _____ Cell Phone _____ Work Phone _____

What is your estimate of your current health? Poor _____ Fair _____ Good _____

HAVE YOU EVER HAD THE FOLLOWING: YES NO YES NO

Hospitalization for illness or injury.....	<input type="checkbox"/>	<input type="checkbox"/>	Stomach or duodenal ulcer.....	<input type="checkbox"/>	<input type="checkbox"/>
Allergic reaction to:			Autoimmune.....	<input type="checkbox"/>	<input type="checkbox"/>
• Aspirin, Ibuprofen.....	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis.....	<input type="checkbox"/>	<input type="checkbox"/>
• Penicillin.....	<input type="checkbox"/>	<input type="checkbox"/>	Contact lenses.....	<input type="checkbox"/>	<input type="checkbox"/>
• Sulfa.....	<input type="checkbox"/>	<input type="checkbox"/>	Head or neck injury.....	<input type="checkbox"/>	<input type="checkbox"/>
• Codeine.....	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy, convulsions (seizures)....	<input type="checkbox"/>	<input type="checkbox"/>
• Sedative.....	<input type="checkbox"/>	<input type="checkbox"/>	Viral infections or cold sores.....	<input type="checkbox"/>	<input type="checkbox"/>
• Local Anesthetics.....	<input type="checkbox"/>	<input type="checkbox"/>	Lumps or swelling in the mouth....	<input type="checkbox"/>	<input type="checkbox"/>
• Latex.....	<input type="checkbox"/>	<input type="checkbox"/>	Hives, skin rash, hay fever.....	<input type="checkbox"/>	<input type="checkbox"/>
• Metals.....	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis (type ____)......	<input type="checkbox"/>	<input type="checkbox"/>
• Any other allergies.....	<input type="checkbox"/>	<input type="checkbox"/>	HIV / AIDS.....	<input type="checkbox"/>	<input type="checkbox"/>
Heart problems.....	<input type="checkbox"/>	<input type="checkbox"/>	Tumor or abnormal growth.....	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur.....	<input type="checkbox"/>	<input type="checkbox"/>	Radiation therapy.....	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever.....	<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy.....	<input type="checkbox"/>	<input type="checkbox"/>
Blood pressure HIGH / LOW.....	<input type="checkbox"/>	<input type="checkbox"/>	Emotional problems.....	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker.....	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric treatment.....	<input type="checkbox"/>	<input type="checkbox"/>
Stroke.....	<input type="checkbox"/>	<input type="checkbox"/>	Antidepressant treatment.....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have heart valve(s)?.....	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol or drug dependency.....	<input type="checkbox"/>	<input type="checkbox"/>
Do you have artificial joint(s)?.....	<input type="checkbox"/>	<input type="checkbox"/>	Taken steroids within the last 2	<input type="checkbox"/>	<input type="checkbox"/>
Date of placement _____			years.....		
Has your MD told you need to take an	<input type="checkbox"/>	<input type="checkbox"/>	Ever taken Bisphosphonates (IV	<input type="checkbox"/>	<input type="checkbox"/>
antibiotic before Dental Treatment?.....			or Oral (Actonel, Bonica,		
Anemia or other blood disorders.....	<input type="checkbox"/>	<input type="checkbox"/>	Fosamax, Skelid, Didronel,		
Prolonged bleeding due to slight cut.....	<input type="checkbox"/>	<input type="checkbox"/>	Aredia, Zometa, Bonefos)		
Tuberculosis.....	<input type="checkbox"/>	<input type="checkbox"/>	ARE YOU:		
Asthma/ Emphysema.....	<input type="checkbox"/>	<input type="checkbox"/>	Presently being treated for illness	<input type="checkbox"/>	<input type="checkbox"/>
Sinus problems.....	<input type="checkbox"/>	<input type="checkbox"/>	Aware of a change in your health..	<input type="checkbox"/>	<input type="checkbox"/>
Kidney disease.....	<input type="checkbox"/>	<input type="checkbox"/>	Often exhausted or fatigued.....	<input type="checkbox"/>	<input type="checkbox"/>
Jaundice or Liver disease.....	<input type="checkbox"/>	<input type="checkbox"/>	Subject to frequent headaches.....	<input type="checkbox"/>	<input type="checkbox"/>
Hormone deficiency.....	<input type="checkbox"/>	<input type="checkbox"/>	A smoker-How many per day? ____	<input type="checkbox"/>	<input type="checkbox"/>
High cholesterol.....	<input type="checkbox"/>	<input type="checkbox"/>	Using a CPAP?.....	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes.....	<input type="checkbox"/>	<input type="checkbox"/>	Are you anxious about dentistry?..	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma.....	<input type="checkbox"/>	<input type="checkbox"/>	FEMALE- use birth control pills...	<input type="checkbox"/>	<input type="checkbox"/>
			FEMALE- pregnant.....	<input type="checkbox"/>	<input type="checkbox"/>
			MALE- have prostate disorder.....	<input type="checkbox"/>	<input type="checkbox"/>

Please describe any current medical treatment, impending or recent surgery, or other treatment that may possibly affect your dental treatment. _____

List (or attach a separate list if extensive) any medications taken within the last two years.

UPDATE - PLEASE ADVISE US OF ANY CHANGE IN YOUR MEDICAL HISTORY AND MEDICATIONS

SIGNATURE _____ DATE _____

Initial _____ Date _____ Initial _____ Date _____ Initial _____ Date _____

DENTAL HISTORY

Referred by _____

Who can we thank for referring to our office: _____

Previous Dentist _____

How long? _____

Last dental exam/ treatment _____

Last dental x-ray _____

How often do you have your teeth cleaned? 3 mo _____ 4 mo _____ 6 mo _____ 1 year or longer _____

WHAT IS YOUR IMMEDIATE DENTAL CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

YES NO

- | | | |
|---|--------------------------|--------------------------|
| 1. Unhappy with the appearance of your teeth..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Unfavorable dental experiences..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Dental fears..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Problems with effectiveness or bad reactions to dental anesthetic..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Orthodontic treatment (braces) / when..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Periodontal (gum) treatment / when..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Bleeding gums..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Do you avoid brushing any part of your mouth..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Part of your mouth sensitive to temperature..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Sore teeth..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. A burning sensation in your mouth..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Difficulty swallowing..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. An unpleasant taste or odor in your mouth..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Dry mouth..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Jaw problems (Temporomandibular joint)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Difficulty opening your mouth widely..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Stiff neck muscles..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Awaken with an awareness of your teeth or jaws..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Tension headaches..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Clench or grind your teeth..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Do you wear a night guard at night..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Lost any teeth | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Do you sweat or tremble a lot during examination | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. Do unfamiliar people or places make you uncomfortable | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. Are you happy with the color of your teeth | <input type="checkbox"/> | <input type="checkbox"/> |

SUPPLEMENTAL DENTURE HISTORY:

If you are wearing a partial or complete artificial denture, please complete the following:

- | | | |
|--------------------------|--------------------------|--|
| YES | NO | (Please check yes or no) |
| <input type="checkbox"/> | <input type="checkbox"/> | Has your present denture been relined? When? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Is your present denture a problem? Describe _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Satisfied with the appearance? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Satisfied with the comfort? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Satisfied with the chewing ability? _____ |
| | | When did you receive your first partial of complete denture? _____ |
| | | How long have you worn your present denture? _____ |

Patient's Signature _____

Date _____

Notice of Privacy Practices – Acknowledgement

By my signature below, I acknowledge that I have read and understand the Notice of Privacy Practices of NW Prosthodontics. I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers for my health care services.
- Conduct normal health care operations such as quality assessment and improvement activities.
- Photos, slides, x-rays or any other viewings of my care and treatment during or after its completion to be used for the advancement of dentistry and reimbursement purposes. My identity will not be revealed to the general public, however, without my permission.

Patient or legally authorized individual signature

Date

Printed name if signed on behalf of the patient

Relationship

For Office Use Only:

We were unable to obtain the patient's written acknowledgment of our Notice of Privacy Practices due to the following reason:

Circle one below:

The patient refused to sign,

Communication Barriers,

Emergency situation,

Other _____

Missed Appointment Policy

We require a **two-business day** advanced notice for any changes or cancellations of your appointments. This allows us the time we initially reserved especially for you in our schedule to be filled by another patient who may have been waiting for this appointment time.

As a courtesy, we make every effort to remind patients of their appointments ahead of time; however, it is ultimately the patient's responsibility to keep their appointments.

- We reserve the right to charge a fee for late cancellations
- If you do not call within 2 business days or "no show" your appointment you will be assessed a \$75 cancellation fee. This is NOT covered by your insurance but will be paid by you directly. Cancellation fees must be paid prior to the start of your next appointment.
- Excessive abuse of scheduled appointments may result in discharge from the practice.

By signing below, I acknowledge that I have read and agree to the above policy.

Signature _____

Date _____

WHAT IS THE BEST WAY TO CONFIRM YOUR APPOINTMENTS?

Home / Work / Cell / Email _____

Written Financial Policy

Thank you for choosing Chandur Wadhvani, DDS, MSD. 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.

Payment Options:

You can choose from:

- Cash, Check and All Major Credit Cards
(We offer a 3% courtesy accounting adjustment to patients who pay for their treatment with **Cash or Check** at the beginning of care for treatment plans of \$1000 or more.)
- We also offer in-house financing, with payments for services spread equally over 3 months with automatic credit card processing.
- Convenient Monthly Payment Options¹ from CareCredit or Lending Club Patient Financing
 - o Allows you to pay over time
 - o Minimum transaction \$1000.00
 - o No annual fees or prepayment penalties

Please note:

Chandur Wadhvani, DDS, MSD requires payment in full prior to the completion of your treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.

For larger, more comprehensive treatment plans of \$1000 or more, a 50% deposit is required to secure your initial treatment appointment.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and provide them with documentation they need to receive reimbursement for your treatment.

We charge 12% APR interest on all past due accounts. There is a \$25 fee for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

Patient, Parent or Guardian Signature

Date

Patient Name (Please Print)

*Subject to credit approval