Health History Form

E-mail: Today's Date:

Referral Source *(circle)*

Drive by Family/friend Facebook Insurance Website

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: ( ) Cell Phone: ( )

Include area codes

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 *For the following questions, 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?	☐	☐	☐
Does food or floss catch between your teeth?	☐	☐	☐
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? Circle one: DAILY / WEEKLY / OCCASIONALLY			
Are you currently experiencing dental pain or discomfort?	☐	☐	☐

	Yes	**No**	**DK**
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?	☐	☐	☐
Do you take aspirin daily?	☐	☐	☐

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:			
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?			
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 diet supplements:			

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 either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis 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 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 In 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	☐	☐	☐

	Yes	No	DK
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	☐	☐	☐
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	☐	☐	☐

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ☐ ☐ ☐

Name of physician or dentist making recommendation: | Phone:

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:

FOR COMPLETION BY DENTIST

Comments: _____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION FOR THE PRACTICE OF CHARLES L. BARBER, D.M.D.

SECTION A: PATIENT GIVING CONSENT

Print Name: _____ _____

_____

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

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 the 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 of other important matters about your protected health information. Our Notice is posted. You may request a copy of our Notice of Privacy Practices including any revisions at any time by contacting:

Contact Person: Donna Kleemook Phone: 412-788-1911 Fax: 412-788-1911
Mailing Address: 6114 Steubenville Pike, McKees Rocks, PA 15136

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, which will contain the changes. 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 the Contact Person listed above. 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.

Signature:
I have had full opportunity to read and consider the contents of the Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

Signed:_____ **Dated:**_____
If this Consent is signed by a representative on behalf of the patient complete the following:

Representative's Name:_____ Relationship to Patient:_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

I have read and am aware that I may receive a copy if I so desire of this office's Notice of Privacy Practices.

Signed: _____ **Dated:** _____

For Office Use:
We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:
_____Individual refused to sign _____ Communications barrier ____ An emergency situation ____ Other

Explanation_____

FAILED APPOINTMENT AGREEMENT

We try faithfully to respect your valuable time by seating you promptly, unless emergency patients have delayed us.

When you do not show up for your scheduled appointment with either the Dentist or the Hygienist, three people lose:

1. You, the patient, do not receive the treatment you need.
2. The patient, who needs treatment immediately and cannot be seen due to a full schedule, loses because we are booked with your appointment.
3. We lose due to the fact that we cannot fill your lost time with anyone else.

You will receive notification of your appointment via text or email 21 days, 7 days and 3 days in advance and/or a phone call 2 days in advance if your appointment is not confirmed. **IF** your appointment **IS NOT** confirmed within 24 hours of your appointment date, **IT WILL BE REMOVED FROM OUR SCHEDULE.** **_____(initials)**

Our office operates on a very high hourly overhead cost basis. We scheduled your time with us just for you. When you do not show up, many people in our office are affected. **IF** you fail to show for a confirmed appointment, please know you will be charged a broken appointment fee and that you are jeopardizing the Dentist/Patient relationship. **The broken appointment fee with the Dentist is $50. The broken appointment fee with the Hygienist is $25.**

_____

Patient Signature Date

_____

Office Signature Date

FAILED APPOINTMENTS CAN RESULT IN PATIENT INACTIVATION

PLEASE COMPLETE OPPOSITE SIDE OF THIS FORM

CHARLES L. BARBER, DMD

6114 Steubenville Pike
Robinson Township
McKees Rocks, PA 15136

Dear Patients:

Please take a few minutes to read over our office financial policy and initial each item in the left-hand margin area. Upon completion, please sign.

Cash Patients/Patients Paying from a Fee Schedule

_____ 1. Our office is a fee for service office. As treatment is rendered, payment is to be made. There are no exceptions. If you desire and with credit approval, you may have your entire treatment plan funded at 0% interest with monthly payments. Applications may be obtained from the office staff.

Participating Insurance Plans

_____ 2. Our office will submit the completed treatment to your insurance company. All unpaid balances (deductible, co-insurance, etc.) are the patient's responsibility. Payment must be made to our office within 30 days to avoid a finance charge. All unpaid balances after 90 days will be submitted for collection.

Non-Participating Insurance Plans

_____ 3. Our office will submit the completed treatment to your insurance company; yet to minimize or avoid billing the following percentages of the cost of your treatment will be paid at the time of service: Crown, Bridges, Partials and Dentures - 100%

Funding is available to all patients for any type of dental work with credit approval.

I have read and agree to the above guidelines.

_____ _____
Patient signature Date

_____ _____
Office Manager Signature Date

Please see other side.

OFFICE POLICIES

1. A 24-hour notice is required to change or cancel all dental appointments. Not giving the 24-hour notice constitutes a failed appointment. Two failed appointments could result in patient inactivation.

2. Our practice has replaced the amalgam (silver fillings) with more functional esthetic materials which we use exclusively. These materials:

   Break down less
   Cause less tooth sensitivity
   Wear more like enamel
   Match your tooth color

   Due to the complexity of these materials, several procedural steps must be taken when placing them. Thus additional costs are incurred. The quality of these restorations far exceeds the minimal costs.

3. I hereby authorize and consent Charles L. Barber, DMD and those qualified perform the treatment plan as explained. I understand that failure to complete restorative and preventative treatment can result in pain and possible tooth loss.

I have read and I understand the above policies.

_____ _____

Patient Signature Date

_____

Doctor Signature

CHARLES L. BARBER, DMD
GENERAL AND COSMETIC DENTISTY
6114 Steubenville Pike
McKees Rocks, PA 15136

Patient Evaluation Form of _____
Patient name and date

We understand how much the appearance of your teeth can affect your overall contentment, happiness, and confidence in the way you feel about yourself. Please answer the following so that we may help you achieve these feelings:

PLEASE CIRCLE YOUR RESPONSE

1. Do you like the appearance of your teeth?
   Yes or No

2. Overall, do you like the appearance of your smile?
   Yes or No

3. Are your teeth all in alignment (straight)?
   Yes or No

4. Do you have spaces between your teeth that you do not like?
   Yes or No

5. Do you like the color of your teeth?
   Yes or No

6. Do you like the shape of your teeth?
   Yes or No

7. Are your teeth chipped, broken or protruding?
   Yes or No

8. Are your teeth worn down on the biting surfaces or near the gum line?
   Yes or No

9. Do you have any crowns or bridges that appear dark at the edge of your gums?
   Yes or No

10. What would you like to change the most about your smile? How would you like your teeth to look?

_____

_____

_____