ZBARASCHUK
DENTAL CARE, PS
Choose Health
Advocates of prevention, wellness, and complete health dentistry

Complete Health Medical & Dental History Form

Although in Dentistry we primarily treat the mouth and all of its structures, the oral cavity is connected to the rest of the body and acts as the Gateway to many of its organ systems. Health problems that you may have or medications that you may be taking could have an important interrelationship with the Dentistry you will receive. Therefore, it is important that you answer all of the pertinent questions. Thank you.

Legal Name: _____ Date: _____

Date of Birth: _____ Preferred Name: _____ Preferred Pronoun: _____

Physical Address: _____

Previous Address (if less than 3 yrs):_____

Mailing Address (if different than above):_____

City: _____ State/Zip: _____ SSN#: _____

Email: _____ _____ Cell Phone:_____

Home Phone: _____ Work Phone: _____ Marital Status:_____

Occupation: _____ Employer: _____

Driver's License#: _____ State: _____

Whom may we thank for referring you to our office? _____

Person responsible for the account is: [ ] Self [ ] Parent [ ] Guardian

Parent or Guardian Information

Name: _____ Marital Status: _____

SSN#_____ Date of Birth: _____ Driver's License #: _____ State: _____

Phone Numbers:

Cell: _____ Home: _____ Work: _____

Physical Address: _____ City: _____

Mailing Address (if different than above): _____State/Zip: _____

Employer Name: _____ Occupation: _____

Employer Address: _____

Personal Health

How would you rate your current health? [ ] Excellent [ ] Good [ ] Fair [ ] Poor

Current age: _____ Weight: ____ _____ Height: _____ Ethnicity: _____

Date of your last **medical** exam: _____ Reason for visit:_____

Names, location & phone #'s of your healthcare team: Preferred Pharmacy: _____

Physician/PCP: _____

Specialists: _____

_____

_____

Medications: Please list all prescription **and** non-prescription medications, vitamins, home remedies, and herbs.

Medication/Supplement Name *Dose (mg per pill, doses per day)* *Start Date*

Allergies or reactions to medicines (RX, OTC, supplements, herbs): _____

List the most recent tests run at your Primary Care Provider's office. List test name and date run.

Personal Medical History

Have you ever been hospitalized for illness? [ ] Yes [ ] No *Please list*

Surgical History

Please list all other operations with the dates when they occurred.

Please indicate whether you have had any of the following medical problems (include dates when occurred).

Periodontal Disease [ ] _____
Dental Infections [ ] _____
Root Canal [ ] _____
Bleeding gums [ ] _____
Heart Disease [ ] _____
Stroke [ ] _____
High Cholesterol [ ] _____
High Blood Pressure [ ] _____
Pre-Diabetes [ ] _____
Diabetes T1/T2 [ ] _____
Mini-Stroke or TIA [ ] _____
Atrial Fibrillation [ ] _____
Poor Blood Flow to Extremities [ ] _____
Aortic Aneurysm [ ] _____
Brain Aneurysm [ ] _____
Bleeding/Clotting Problems [ ] _____
Blood Transfusions [ ] _____
Anemia [ ] _____
High Red Blood Cell Count [ ] _____
Leukemia [ ] _____
Abnormal Platelet Count [ ] _____
Stomach Ulcers [ ] _____
Chronic Heartburn [ ] _____
Cancer [ ] _____
Physical Disability [ ] _____
Mental Disability [ ] _____
PTSD [ ] _____
Blood Clot in Legs [ ] _____
COVID-19 [ ] _____
Hospitalized for treatment of COVID Yes/No
Vaccinated for COVID Yes/No Brand _____ Date(s): _____

Heart Arrhythmia [ ] _____
Heart Valve Problem [ ] _____
Rheumatoid Arthritis [ ] _____
Kidney Disease [ ] _____
Kidney Stones [ ] _____
Gallbladder Stones [ ] _____
Pancreatic Disease [ ] _____
Fatty Liver Disease [ ] _____
Lupus [ ] _____
Psoriasis [ ] _____
Sjorgren's Syndrome [ ] _____
Autoimmune Disorder [ ] _____
Gout [ ] _____
Polycystic Ovaries [ ] _____
Thyroid Problems [ ] _____
Depression [ ] _____
Suicide Attempts [ ] _____
Anxiety/Panic Attacks [ ] _____
Migraine Headaches [ ] _____
Osteoporosis/penia [ ] _____
Restless Legs [ ] _____
Sleep Disorder [ ] _____
Acid Reflux/GERD [ ] _____
History Hepatitis/type [ ] _____
Alcoholism [ ] _____
Drug Use [ ] _____
History of AIDS [ ] _____
Other *list* [ ] _____

Social History

Tobacco use

Cigarettes: [ ] Never [ ] Quit: date you quit _____ [ ] Current smoker (packs per day) _____
Other tobacco (check all answers that apply): [ ] Pipe [ ] Cigar [ ] Chewing Tobacco [ ] e-cigarettes [ ] Marijuana
Number of years you've used this tobacco: _____ Are you interested in quitting? [ ] Yes [ ] No
Have you tried to quit in the past? [ ] Yes [ ] No How many times have you tried to quit? _____
What methods have you tried? _____
Are you exposed to second-hand smoke? [ ] Yes [ ] No If yes, for how long? _____

Alcohol use
Do you drink alcohol? [ ] Yes [ ] No
If yes, how many drinks do you consume per week? _____ Alcohol type _____
Does your alcohol consumption have you or others concerned? [ ] Yes [ ] No

Other concerns
Caffeine intake: Coffee _____cups/day Tea _____cups/day Sodas per day _____ [ ] Diet [ ] Regular
Chocolate _____ ounces per day [ ] Dark [ ] Light
Do you drink energy drinks or take pills to stay awake? [ ] Yes [ ] No If yes, specify _____
Decaffeinated products? [ ] Yes [ ] No if yes, specify what/how much _____

Exercise
Do you exercise regularly? [ ] Yes [ ] No What kind of exercise? _____
How long do you exercise in minutes? _____ How often? _____
If you do not exercise, why not? _____
Do you have any limitations to your ability to exercise? Please explain _____

Hobbies or Special Interests _____
_____

Personal History
Occupation _____ Employer _____
Years of education/highest degree _____
Marital status: [ ] Single [ ] Married [ ] Divorced [ ] Widowed [ ] Other
Spouse/partner's name _____
Who lives at home with you? _____
How many children do you have? Please provide names, gender, and ages. _____
_____
Where were you born? _____ Where did you grow up? _____
How long have you lived in this area? _____

History for Women
How many times have you been pregnant? _____ How many deliveries? _____ Miscarriages? _____
Please list any problems you have experienced with pregnancy or delivery: _____
_____
When was the first day of your most recent period? _____What was your age at your first period? _____
Frequency of periods _____ Length of each _____ [ ] Regular [ ] Irregular
Menopause? [ ] Yes [ ] No Hysterectomy? [ ] Yes [ ] No When _____Ovaries removed? [ ]Yes [ ] No
Do you have any history of gestational diabetes? [ ] Yes [ ] No
High blood pressure or eclampsia with pregnancy? [ ] Yes [ ] No

Oral Health

Is there a specific dental problem that you currently have? _____
How many times per day do you brush your teeth? _____What type of toothbrush do you use?_____
How often do you floss? _____Type of floss used _____
How often have you seen a dentist? _____ Do you ever have bleeding gums? [ ] Yes [ ] No
Does your oral health concern you? [ ] Yes [ ] No If yes, why?_____
Previous dentist's name: _____Date of last treatment: _____
Reason for change in providers: _____

Check (√) if you have had problems with any of the following:

□ Bad Breath	□ Loose teeth or broken fillings	□ Sensitivity when biting
□ Grinding Teeth	□ Sensitivity to sweets	□ Food collection between teeth
□ Sensitivity to hot	□ Clicking or popping jaw	□ Sensitivity to cold
□ Bleeding gums	□ Periodontal treatment	□ Sores or growths in your mouth

Would you be interested in straighter teeth with clear aligner therapy? [ ] Yes [ ] No
Whiter teeth? [ ] Yes [ ] No Reducing snoring? [ ] Yes [ ] No

Stress

How would you classify your stress level at work? [ ] Low [ ] Medium [ ] High
How would you classify your stress level at home? [ ] Low [ ] Medium [ ] High
Do you often feel anxious, angry, irritated or rushed? [ ] Yes [ ] No
How do you manage your stress? _____
Do you meditate daily? [ ] Yes [ ] No If yes, how? _____
Do you perceive a lack of control of your environment? [ ] Yes [ ] No If yes, why? _____

Diet

How do you rate your diet? [ ] Good [ ] Fair [ ] Poor
Do you currently see a dietitian? [ ] Yes [ ] No If yes, how often and who? _____
How many daily servings of the following do you have:

Whole grains _____	Fruit _____	Vegetables _____
Water _____	Nuts _____	Milk_____%_____

How many times a week do you consume the following items?

Processed foods _____	Butter _____	Eggs _____
Chicken/Turkey _____	Margarine _____	Red Meat _____
Dairy Products _____	Fish _____	Fried Foods _____
Eat out _____		

Do you have any food allergies or food sensitivities? [ ] Yes [ ] No If yes, please explain _____
_____
Are you satisfied with your weight? [ ] Yes [ ] No List any weight goals _____

Travel History

Any recent International Travel? [ ] Yes [ ] No
If yes, what countries and dates of stay _____
Any illnesses during or post travel? _____

Review of Symptoms

Please check any current problems you have on the list below.

Constitutional

[ ] Swelling (Explain) _____

[ ] Change in energy/increased weakness

[ ] Unexplained weight loss/gain

[ ] Brittle nails

[ ] Dry skin

[ ] Excessive thirst or urination

[ ] Change in hair texture

[ ] Inability to stand heat

[ ] Inability to stand cold

[ ] Changes in skin texture

Respiratory

[ ] Snoring

[ ] Cough/wheeze

[ ] Frequent respiratory infections

[ ] Difficulty breathing

[ ] Sleep apnea/CPAP

Eyes

[ ] Change in vision (Explain) _____

[ ] History of retinal tear or hemorrhages

[ ] Frequent irritation

[ ] Cataracts (Surgery?) _____

[ ] Double vision

[ ] Dry eyes

[ ] Glaucoma (Treatment?) _____

Ear/Nose/Throat/Mouth

[ ] Difficulty hearing/ringing in your ears

[ ] Dental Cavities

[ ] Root Canals

[ ] Hay fever/allergies

[ ] Painful teeth or gums

[ ] Dental Implants

[ ] Bleeding gums

[ ] Bad breath

Cardiovascular

[ ] Chest pain/discomfort

[ ] Swelling in feet or legs

[ ] Spine problems

[ ] Palpitation (irregular heart beat)

[ ] Pain in extremities with exercise

[ ] Varicose veins

[ ] Neck problems

[ ] Muscle injuries

Skin

[ ] Acanthosis nigricans (dark lines around neck or under arms)

[ ] Flattening of nail beds

[ ] Skin tags

[ ] Creases in earlobes

[ ] Skin infections

[ ] Frequent itching of skin

Genitourinary

[ ] Increased urination that interrupts sleep

[ ] Unusual frequency of urination

[ ] Blood in urine

Gastrointestinal

[ ] Blood in bowel movement

[ ] Abdominal pain

[ ] Weight loss

[ ] Heartburn

[ ] Diarrhea/constipation

[ ] Weight gain

[ ] Nausea/vomiting

[ ] Loss of appetite

[ ] Diverticulitis/Diverticulosis

Neurological

[ ] Headaches

[ ] History of torn or ruptured tendons

[ ] Tingling, pain, or numbness in hands/feet

[ ] Light-headedness

[ ] History of bone fractures

[ ] Loss of coordination

[ ] Memory loss

[ ] Arthritis

Psychiatric

[ ] Problems with sleep

[ ] Mania

[ ] Short temper or impatience

[ ] Hopelessness and constant worry

[ ] Depression

[ ] Anxiety/Panic attacks

[ ] Unusual feeling of doom

[ ] Anger issues

Blood/Lymphatic

[ ] Easy bruising/bleeding

[ ] Unusually pale

[ ] History of low white blood cell counts

[ ] Unexplained lumps

[ ] History of blood clots

[ ] History of high platelet counts

[ ] Unusual bleeding

[ ] History of low platelet counts

[ ] History of anemia

Muscle/Skeletal-Chronic

[ ] Joint problems

[ ] Any muscle side effects from Statin use

[ ] Paralysis of any muscles

[ ] Unusual muscle weakness

[ ] Back problems

[ ] Joint Replacement _____

Family History

Please indicate with a check mark any family members who have had any of the following medical conditions:

Medical Condition	Mom	Dad	Sister	Brother	Daughter	Son	Other-MM/MD/DM/DD MS/MB/DS/DB
Heart Attack							
Stroke							
Diabetes-Type 2							
Alcoholism							
Anemia							
Aortic Aneurysm							
Alzheimer's							
Arthritis							
Autoimmune Disorder							
Bleeding Problems							
Carotid Artery Disease							
Cancer-Type							
Coronary Stents							
Coronary Bypass							
Depression							
Diabetes-Type 1							
Epilepsy (seizure disorder)							
Other Genetic Disorders							
High Cholesterol (hyperlipidemia)							
High Blood Pressure (hypertension)							
Immunosuppressive Disorders							
Kidney Disease							
Mini Strokes/TIA							
Osteoporosis Osteopenia							
Polycystic Ovary Disease							
Substance Abuse							
Sleep Apnea							
Smoking							
Thyroid Disorder							
Gum Disease							
"Bad" Teeth							

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Dental Insurance Information

Subscriber Name: _____ Relation to Patient: _____

Date of Birth: _____ SSN# _____ ID# (listed on card): _____

Mailing Address & Phone# *(If different from patient):* _____

_____

Insurance Company Name & Address: _____

_____

Subscriber Employed by: _____ Work Phone: _____

Medical Insurance Information

Subscriber Name: _____ Relation to Patient: _____

Date of Birth: _____ SSN# _____ ID# (listed on card): _____

Mailing Address & Phone# *(If different from patient):* _____

_____

Insurance Company Name & Address: _____

_____

Subscriber Employed by: _____ Work Phone: _____

Emergency Contact Information

Name of nearest relative not living with you & relationship: ___ _____

Complete address: _____

Best phone number to reach them: _____

I hereby certify the above information is true and correct.

_____

Signature of Patient (or Parent/Guardian if minor) Date

For office use only.
Notes: _____
_____
Reviewed Health History: _____ *Date:* _____
_____ *Date:* _____

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Office Financial Policies and Federal Truth-in-Lending Statement

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from our patients for the costs' incurred in their care to remain viable. Therefore, financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are rendered.

Patients that carry dental insurance understand that all dental services not paid by the insurance company within 60 days are charged directly to the patient and are responsible for payment of all dental services. This office will help prepare the insurance forms of our patients or assist in making collections from insurance companies and will credit any such collections received to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid in full by an insurance company.

A service charge of 1.5% per month (18% per annum) of the unpaid balance will be added monthly on all accounts exceeding sixty days from the date of service unless previously written financial arrangements are made. I understand that the fee estimated listed for this dental care can only be extended for a period of six (6) months from the date of the patient examination.

We realize that unforeseen problems do come at the last moment. Therefore, we will not charge a fee for the first missed appointment. We do ask that you be courteous to other patients and our staff by giving us 48 hours prior notice if you need to change or cancel an appointment.

In consideration for the professional services rendered to me, or at my request for my minor child or ward by the dentist, I agree to pay, the fees charged for the dental services provided by Zbaraschuk Dental Care, PS or its licensed employees at the time said services are rendered, or within five (5) days of billing if credit is extended by the dentist. I understand that if I do not keep this arrangement and I default on my agreement, this account will be placed with a collection agency where I will be responsible for any court costs, all attorney fees, filing fees, late changes, finance changes including charges of commissions of 40% that may be assessed to me by a collection agency retained to pursue this matter, with or without suit, and interest up to the maximum allowed by law per annum. I authorize the release of financially identifiable information concerning my account, including charges billed, payments made, and interest charges assessed, etc. to the dentist's collection agency or attorney should collection procedures as described become necessary. This agreement supersedes all prior agreements signed related to financial arrangements or quality of care and are now null and void. I understand that, where appropriate, credit bureau reports may be obtained.

I grant my permission to Zbaraschuk Dental Care, PS or assignees to telephone me at home, on my cell, or at my workplace to discuss matters related to this form. I also agree to let this office leave messages concerning appointments and/or results on my answering machine or with a family member.

I authorize Zbaraschuk Dental Care, PS or designee's to release financially identifiable information and treatment descriptions and information, either electronically, by facsimile or in paper form to my insurance carrier or any related entities that require such information to be submitted.

I hereby agree to abide by the conditions outlined hereon.

Signature of patient, parent or guardian | Date | Relationship to Patient

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Insurance, Responsibilities and Estimates

Please note that **ALL QUOTES AND PRICES ARE ESTIMATES** when insurance is factored in. Co-payments and estimated patient portions are due at the time of service.

It is the responsibility of the patient to know his/her individual insurance coverage and follow through with his/her company to see that payments are made. Also be aware of your renewal dates of coverage, benefit cycle and maximum benefits paid.

The front office staff is providing a service for you in inquiring about your coverage and is striving to give you the most accurate information. We cannot guarantee that the services will be covered according to the information we have been given. All rendered procedures that are not covered by the insurance are the patient's responsibility.

I understand that I am solely responsible for the full payment of services received from Zbaraschuk Dental Care, PS on **ANY and ALL** procedures that are uncovered and/or denied by my insurance company.

By signing, I agree to pay for all services, in full, received from Zbaraschuk Dental Care, PS in accordance with the "Office Financial Policies and Federal Truth-in-Lending Statement" that are denied and/or otherwise not covered by my insurance company.

I hereby authorize insurance payment directly to Zbaraschuk Dental Care, PS when assignment allows and agree to abide by the conditions outlined above.

Signature of patient, parent or guardian Date Relationship to Patient

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Acknowledgement of Receipt of Statement of Privacy Practices

I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of Zbaraschuk Dental Care P.S.. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Zbaraschuk Dental Care P.S. reserves the right to change the privacy practices currently described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed or otherwise transmitted to me.

ADDITIONAL DISCLOSURE AUTHORIZATION

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my Protected Healthcare Information to the person(s) identified below. (I understand that the default answer is "NO". Without indicating "YES" in answer to each individual question, personal protected (PHI) cannot be shared with anyone unless otherwise allowed by HIPAA.)

Spouse only		☐ **YES**	☐ **NO**
OR			
Any Member of my immediate family: (i.e. Spouse, Children, Children's Spouses)		☐ **YES**	☐ **NO**
Any Member of my extended family: (i.e. Parents, Grandchildren)		☐ **YES**	☐ **NO**
OTHER: (Name)	**Telephone #:**	☐ **YES**	☐ **NO**

Name of patient (please print):

Patient signature (if 18+ years of age):

Patient's personal representative: (Please Print):

Personal Representative's signature:

Representative's Telephone Number: **Date:**

OFFICE USE ONLY BELOW THIS LINE

Acknowledgement Not Obtained			
Provided Prior to Treatment?	☐ **YES**	☐ **NO**	**Date Statement Provided:**
Reason for not obtaining patient signature:	☐	**Needed more time to review Statement**	
	☐	**Wanted to consult another person before signing**	
	☐	**Physically unable to sign**	
	☐	**No reason offered**	

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RECORDS REQUEST

Patient Name: _____

DOB: _____

MEDICAL: _____DENTAL:_____
Practice/PCP

_____|_____
Mailing Address

_____|_____
City, State, Zip

_____|_____
Email Address

_____|_____
FAX NUMBER

I hereby authorize the above named provider to release and transfer the following information via email OR fax to:

Zbaraschuk Dental Care, PS
645 N 5th Ave
Sequim, WA 98382
doctor@zbaraschukdental.com
Office 360-683-3626 Fax 360-683-2384

The most recent:
Complete Labs
History/Physical/Assessment
Films/Periodontal Charting/Photo's

Date_____ _____
Signature

_____
Witness Signature