Chris Henson, D.D.S.
4333 College Hills Blvd.
San Angelo, Texas 76904

Medical-Dental Health Questionnaire

PATIENT INFORMATION

Patient Name: _____ ◊ Male ◊ Female
Last First MI

Social Security#: _____ Birth Date: _____ DL: _____

Address: _____ ◊ Married ◊ Single ◊ Child ◊ Other _____

_____ Email Address: _____

Hm#: _____ Cell#: _____ Wrk#: _____

HEALTH INFORMATION

Date of last dental visit: _____ Reason for this visit: _____

Please indicate which currently apply:

◊ AIDS / HIV
◊ Anemia
◊ Arthritis
◊ Artificial Joints
◊ Asthma
◊ Back Problems
◊ Blood Disease
◊ Cancer _____
◊ Chemical Dependency
◊ Diabetes _____
◊ Dizziness
◊ Dry Mouth Syndrome
◊ Epilepsy
◊ Excessive Bleeding
◊ Emphysema
◊ Fainting
◊ Glaucoma
◊ Growths _____
◊ Hay Fever
◊ Head Injury
◊ Heart Disease / Attack
◊ Heart Murmur / MVP
◊ Hepatitis _____
◊ High Blood Pressure
◊ Intestinal Disease
◊ Kidney Disease
◊ Latex Allergy
◊ Liver Disease
◊ Metal Allergies
◊ Mental Disorders _____
◊ Neurological Disorders _____
◊ Nursing
◊ Pacemaker
◊ Persistent Cough
◊ Phobias
◊ Pregnancy
Due Date: _____
◊ Radiation Treatment
◊ Recreational Drugs
◊ Respiratory Problems
◊ Rheumatic Fever
◊ Rheumatism
◊ Seizures _____
◊ Shortness of Breath
◊ Sinus Problems
◊ Stomach Problems
◊ Stroke
◊ Thyroid Problem
◊ Tobacco Habit _____
◊ Tuberculosis
◊ Tumors
◊ Ulcers
◊ Venereal Disease _____
◊ PreMed Required _____
OTHER:
_____
_____

- Have you ever had any complications following or during dental treatment? ◊ YES ◊ NO
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past 2 years? ◊ YES ◊ NO
  If yes, please explain: _____
- Are you now under the care of a physician? ◊ YES ◊ NO • Physician's Name/ Phone#: _____
  If yes, please explain: _____
- Do you have health problems that need further clarification? ◊ YES ◊ NO
  If yes, please explain: _____

MEDICATIONS

Please list all medications that you are currently taking:

_____
_____
_____
_____

Please list all **allergies** to medications:

_____
_____
_____
_____

To the best of my knowledge, all of the information provided above is accurate. If /when any of my information changes, I will update Dr. Henson's office without fail. Dr. Henson's office has my permission to obtain any additional information with regard to my medical history from my physician.

_____ Date: _____
Signature of patient, parent, or guardian

Consent for Services / Financial Policy / Assignment of Benefits

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patient(s) for the costs incurred in their care; financial responsibility on the part of each patient must be determined before treatment. It is our Standard of Practice to collect all co-pays and deductibles at the time services are rendered.

We accept cash, check, MasterCard, Visa, or Care Credit financing for payment of services.

All services performed without previous financial arrangements must be paid at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he/she is personally responsible for payment of all dental services. **Insurance benefits are a contract between the patient and the insurance company.** This office will help prepare patient insurance forms or file claims to the insurance company, and will credit any such payments sent to our office to the patient account. However, this dental office will not render services on the assumption that our charges will be paid by an insurance company.

A late fee will be assessed for a minimum of $25, up to 40% of the outstanding balance on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied. In the event that a payment by check is returned insufficient, a fee of up to $25 will be assessed.

I understand that the fee estimate listed for dental care can only be extended for a period of six months from the date that the treatment plan was originally produced by this office. In the event that a treatment plan is requested from an insurance company, I understand that their payment estimates are not a guarantee of payment. Such estimates will only be considered for the duration listed on estimate.

In consideration for the professional services rendered to me, or at my request by the doctor, I agree to pay therefore the reasonable value of said services to said doctor, or his assignee at the time said services are rendered. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition, and I further agree to pay all cost and reasonable attorney fees if suit be instituted hereunder.

I understand that for my treatment to begin without delay and to maximize its effectiveness, I must notify this office at least one business day in advance regarding changes to scheduled appointments and that there may be fees for no or late notification.

I grant my permission to you or your assignee to telephone me at home or at my place of employment to discuss matters related to this form.

I have read the above conditions of treatment and payment, and I agree to their content. I, the undersigned, certify that I [or my dependent(s)] have insurance coverage as noted below and assign directly to Dr. Chris Henson all insurance benefits, if any, otherwise payable to me for services rendered. I authorize the use of this signature in all my insurance submissions. I hereby authorize the doctor to release all information necessary to secure the payment of benefits undersigned, give consent for myself (or my dependents) to receive the treatment recommended to me by Dr. Chris Henson.

Dental Insurance Carrier: _____ **Policyholder:** _____

Insured Employer: _____ **Ph# for ins. co.** _____

Member ID#: _____ **Group#:** _____

Relationship

Signature_____ **To Patient:** _____ **Date:** _____

Referral Information

Whom may we thank for referring you to our practice? ◊ Another Patient, relative ◊Another Patient, friend ◊ Dental Office ◊ Yellow Pages

◊ Work ◊School ◊ Newspaper ◊ Other: _____

Name of the person or office referring you to our practice: _____