

Health History Form

Email: _____ Today's Date: _____

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:			Home Phone: <i>Include area code</i>	Business/Cell Phone: <i>Include area code</i>	
<i>Last</i>	<i>First</i>	<i>Middle</i>	()	()	
Address:			City:	State:	Zip:
<i>Mailing address</i>					
Occupation:			Height:	Weight:	Date of Birth: Sex: M F
SS# or Patient ID:	Emergency Contact:		Relationship:	Home Phone: <i>Include area code</i>	Cell Phone: <i>Include area code</i>
			()	()	
If you are completing this form for another person, what is your relationship to that person?					
<i>Your Name</i>			<i>Relationship</i>		
Do you have any of the following diseases or problems:			<i>(Check DK if you Don't Know the answer to the question)</i>		Yes No DK
Active Tuberculosis					<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Persistent cough greater than a 3 week duration					<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Cough that produces blood.....					<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Been exposed to anyone with tuberculosis.....					<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.					

Dental Information *Please mark (X) your responses to the following questions.*

	Yes	No	DK		Yes	No	DK
Do your gums bleed when you brush or floss?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have earaches or neck pains?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive to cold, hot, sweets or pressure?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any clicking, popping or discomfort in the jaw?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your mouth dry?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you brux or grind your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any periodontal (gum) treatments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have sores or ulcers in your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had orthodontic (braces) treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you wear dentures or partials?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any problems associated with previous dental treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you participate in active recreational activities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your home water supply fluoridated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had a serious injury to your head or mouth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you drink bottled or filtered water?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Date of your last dental exam:			
If yes, how often? <i>(Check one):</i> DAILY <input type="checkbox"/> / WEEKLY <input type="checkbox"/> / OCCASIONALLY <input type="checkbox"/>				What was done at that time?			
Are you currently experiencing dental pain or discomfort?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	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		Yes	No	DK
Are you now under the care of a physician?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you had a serious illness, operation or been hospitalized in the past 5 years?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physician Name: _____				If yes, what was the illness or problem?			
Phone: <i>Include area code</i>							
()							
Address/City/State/Zip:							
				Are you taking or have you recently taken any prescription or over the counter medicine(s)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you in good health?				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Has there been any change in your general health within the past year?				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
If yes, what condition is being treated?				If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements:			

Date of last physical exam:							

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)

Do you wear contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Do you use controlled substances (drugs)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK
Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Date: _____ If yes, have you had any complications? _____	Do you use tobacco (smoking, snuff, chew, bidis)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK If so, how interested are you in stopping? Circle one: VERY / SOMEWHAT / NOT INTERESTED
Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax*, Actonel*, Atelvia, Boniva*, Reclast, Prolia) for osteoporosis or Paget's disease? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Do you drink alcoholic beverages? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK If yes, how much alcohol did you drink in the last 24 hours? _____ If yes, how much do you typically drink in a week? _____
Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia*, Zometa*, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Date Treatment began: _____	WOMEN ONLY Are you: Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Number of weeks: _____ Taking birth control pills or hormonal replacement? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Nursing? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK

Allergies. Are you allergic to or have you had a reaction to:
To all **yes** responses, specify type of reaction.

Local anesthetics <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Metals _____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK
Aspirin <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Latex (rubber) _____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK
Penicillin or other antibiotics <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Iodine _____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK
Barbiturates, sedatives, or sleeping pills <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Hay fever/seasonal _____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK
Sulfa drugs <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Animals _____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK
Codeine or other narcotics <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Food _____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK
	Other _____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

Artificial (prosthetic) heart valve <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Autoimmune disease <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK
Previous infective endocarditis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Rheumatoid arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Hepatitis, jaundice or liver disease <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK
Damaged valves in transplanted heart <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Systemic lupus erythematosus <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Epilepsy <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK
Congenital heart disease (CHD) Unrepaired, cyanotic CHD <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Fainting spells or seizures <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK
Repaired (completely) in last 6 months <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Bronchitis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Neurological disorders <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK If yes, specify: _____
Repaired CHD with residual defects <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Sleep disorder <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK
	Sinus trouble <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Do you snore? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK
	Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Mental health disorders <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Specify: _____
	Cancer/Chemotherapy/ Radiation Treatment <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Recurrent Infections <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Type of infection: _____
	Chest pain upon exertion <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Kidney problems <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK
	Chronic pain <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Night sweats <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK
	Diabetes Type I or II <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Osteoporosis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK
	Eating disorder <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Persistent swollen glands in neck <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK
	Malnutrition <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Severe headaches/migraines <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK
	Gastrointestinal disease <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Severe or rapid weight loss <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK
	G.E. Reflux/persistent heartburn <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Sexually transmitted disease <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK
	Ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Excessive urination <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK
	Thyroid problems <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	
	Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

Cardiovascular disease <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Mitral valve prolapse <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK
Angina <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK
Arteriosclerosis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Rheumatic fever <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK
Congestive heart failure <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Rheumatic heart disease <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK
Damaged heart valves <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Abnormal bleeding <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK
Heart attack <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK
Heart murmur <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Blood transfusion <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK If yes, date: _____
Low blood pressure <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Hemophilia <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK
High blood pressure <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	AIDS or HIV infection <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK
Other congenital heart defects <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? Yes No DK

Name of physician or dentist making recommendation: _____ Phone: Include area code () _____

Do you have any disease, condition, or problem not listed above that you think I should know about? Yes No DK
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: _____

Signature of Dentist: _____ Date: _____

FOR COMPLETION BY DENTIST

Comments: _____



WELLNESS

Periodontology & Implantology Group
Josué Padilla DMD, MS, Ph.D.

Who is your Referring Doctor: _____

Who is your General Dentist: _____

DENTAL INSURANCE INFORMATION

Do you have Dental Insurance? _____ Yes _____ No

Name of insured _____

Relationship to patient _____

Insurance Company _____

Group or employer number _____

Policy number _____

Policyholder's date of birth _____

Insurance company address, city, state, ZIP: _____

Insurance company phone _____

Employer _____

Do you have secondary dental insurance? _____ Yes _____ No

Name of insured _____

Relationship to patient _____

Insurance Company _____

Group or employer number _____

Policy number _____

Policyholder's date of birth _____

Insurance company address, city, state, ZIP: _____

Insurance company phone _____

Employer _____



OFFICE FINANCIAL POLICY

It is our policy to discuss treatment plans with all patients or guardians before dental treatment is started. A complete estimate of fees and method of payment will be discussed after your initial consultation.

Dental Insurance: This office is happy to cooperate with individuals who are covered by dental insurance. We ask that you carefully read your policy to be sure that you are fully aware of any restrictions that apply to the benefits provided. Dental insurance is a contract between the patient and the insurance company, Dr. Padilla participates with Blue Cross Blue Shield/Excellus dental program directly, but the office will file all claims for all insurance companies.

To prevent any misunderstanding concerning dental insurance payment, the following policy has been established:

1. Payment for surgery must be paid one week prior to your scheduled date
2. We will complete and mail your insurance forms for you. Please keep in mind that you are responsible for payment for services rendered
3. A pre-estimate form can be submitted to your insurance company for authorization of benefits prior to treatment being started. Please keep in mind that these may take 4 to 6 weeks for a reply
4. Pre-determinations are not a guarantee of payment. It is the patient's responsibility to know how much their yearly benefit is remaining for the year. Most insurance companies have websites so that you can conveniently access what benefits you have used and/or how much you have left for the year

Method of payment:

1. Full payment at each appointment is expected in the form of cash, check, credit card (Visa, MasterCard, Discover, American Express, debit card or care credit)
2. Care Credit: if you would like to make payment arrangements, please see our front desk for information on this program
3. Interest charges of 1.5% per month are placed on the account if payment is 60 days past due

Cancellation Policy:

1. There will be a **\$50 charge** for any periodontal maintenance appointment that is not cancelled 48 hours prior to your scheduled visit
2. There will be a **\$500 charge** for any surgical appointment that is not cancelled one week prior to your scheduled appointment

I have read and understand my financial responsibility at Wellness Periodontology & Implantology Group/ Dr. Padilla's office. If my account goes past 90 days, I understand I will be responsible for any charges associated with collection proceedings.

Patient signature: _____ Date: _____



HIPAA Acknowledgement of Receipt of Notice of Privacy Practices

**I am aware the Notice of Privacy Practices can be found on the wellness website:
www.wellnessperio.com at the bottom of the page or ask for a printed copy in office.**

Print name: _____

Signature: _____

Date: _____

The following person(s) may receive information regarding my protected patient information:

I understand that I may revoke this authorization at any time, and that my revocation is not effective unless it is in writing and received by the dental practice's Privacy Official at 1815 S. Clinton Ave. Suite 500, Rochester, NY 14618. If I revoke this authorization, my revocation will not affect any actions taken by the dental practice before receiving my written revocation.

I understand I may refuse to sign this authorization, and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits.

This authorization expires on the following date, or when the following event occurs: _____

Below this line for office use only

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
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

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