# Welcome to Henniker Family Dentistry

K. Drew Wilson, DMD, MAGD - Joshua T. Osofsky, DMD - John S. Echternach, DDS- Michael Hockberg, DMD

*Please take a few minutes to answer the following questions. Your answers will help us assist you with your healthcare needs.*

**About You…..** Today's date:_____

Name:_____DOB:_____SS#:_____

Address:_____ I like to be called:_____

Marital Status: Single Married Divorced Separated Widowed

Name of spouse:_____ Names of children:_____

Employer_____I

If you could wave a magic wand and change anything about your smile, what would you like to do?

_____

_____

**Contact Information…**

Home phone:_____ Business phone:_____

Cell phone:_____ E-mail address:_____

Are you willing to accept appointment confirmations by:

**Text: Yes No E-mail: Yes No**

Person to contact in case of emergency:_____

Emergency phone number:_____

Would you like anyone else to have the ability to discuss your dental treatment/account with us? If so, who:_____

**Insurance…**

Name of primary benefit plan: _____ Name of secondary insurance: _____

Insurance company address: _____ Insurance Company address: _____

_____ _____

_____ _____

Group #_____ Group #_____

Policy #_____ Policy #_____

Policyholder's name: _____ Policyholder's name:_____

Policyholder's birth date:_____ Policyholder's birth date:_____

Policyholder's SS #:_____ Policyholder's SS#:_____

I affirm that the information that I have given is correct to the best of my knowledge. It will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to provide the dental services I will need. I assign directly to Henniker Family Dentistry all insurance benefits, otherwise payable to me. I understand that I am responsible for payment of services rendered and am also responsible for paying any co-payment, deductible, or procedure that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits.

Signature:_____Date:_____

PAYMENT IS DUE AT TIME OF SERVICE

# **Medical & Dental History-**Personal and Confidential

**Do you have any of the following diseases or medical problems?**

- ❑ Active tuberculosis
- ❑ Been exposed to anyone with tuberculosis
- ☐ Persistent cough greater than a 3-week duration
- ☐ Cough that produces blood

**If you marked any of the above items, please stop and return this form to the receptionist.**

Name of personal physician: _____ Approximate date of last visit: _____

Address & phone #: _____

Have you had any serious illness, operation or been hospitalized in the last five years? YES / NO If yes, please explain:

_____

Has there been any changes in your general health within the past year or are you being treated for a condition now? YES / NO

If yes, please explain:_____

## Dental Information:

| | | |
|---|---|---|
| Have you had periodontal treatment? | Yes | No |
| Do you wear dentures or partial? | Yes | No |

Please check if you are allergic to any of the following:

- ☐ Local anesthetics
- ☐ Penicillin/other antibiotics
- ☐ Barbiturates, sedatives, sleeping pills
- ☐ Sulfa drugs
- ☐ Aspirin
- ☐ Other
- ☐ Codeine/other narcotics
- ☐ Latex sensitivity

**Describe Reaction:**_____

The following conditions **may require** a **pre-medication** with antibiotics. Please check if any of them apply to you (or have in the past)

- ☐ Prosthetic implant
  - Joint & date: _____
- ☐ Transplant surgery
  - Organ & date: _____
- ☐ Artificial (prosthetic) heart valve

**Prescription or Non Prescription or Herbal Medications**
**List all medications and Herbal Supplements/Remedies that you are currently taking**

Name:_____Dose:_____
Name:_____Dose:_____
Name:_____Dose:_____
Name:_____Dose:_____
Name:_____Dose:_____
Name:_____Dose:_____

Are you taking or scheduled to begin any Bisphosphonate Therapy such as Fosamax or Actonel? YES / NO

Since 2001, were you treated or are scheduled to begin treatment with intravenous Bisphosphonates (Aredia or Zometa) for bone pain, hypocalcemia or skeletal complications resulting from Osteoporosis, Paget's Disease, Multiple Myeloma or Metastatic Cancer? YES / NO

PLEASE COMPLETE BOTH SIDES

Please circle YES or NO for any illness that you currently have or previous had

| **HEART OR BLOOD DISORDERS** | | | | **OTHER CONDITIONS** | | | |
|---|---|---|---|---|---|---|---|
| Artificial Heart Valve | | Yes | No | Kidney Problems/Dialysis | | Yes | No |
| Congenital Heart Defect | | Yes | No | Liver Disease | | Yes | No |
| Heart Murmur | | Yes | No | Artificial Joints | | Yes | No |
| Angina | | Yes | No | Type: | Date: | | |
| Congestive Heart Failure | | Yes | No | Cancer | | Yes | No |
| Heart Surgery | | Yes | No | Chemotherapy | | Yes | No |
| Heart Attack | | Yes | No | Radiation | | Yes | No |
| Prosthetic Heart Valve | | Yes | No | Persistent Swollen Glands | | Yes | No |
| Pacemaker/Defibrillator | | Yes | No | Osteroporosis | | Yes | No |
| Bacterial Endocarditis | | Yes | No | Chronic Pain | | Yes | No |
| Coronary Artery Diseases | | Yes | No | Pregnant | | Yes | No |
| High Blood Pressure | | Yes | No | Due Date: | | | |
| Hemophilia | | Yes | No | Nursing | | Yes | No |
| Anemia | | Yes | No | OTHER: | | | |
| OTHER: | | Yes | No | | | | |
| | | | | | | | |
| **RESPIRATORY/LUNG CONDITIONS** | | | | **INFECTIOUS DISEASE** | | | |
| Asthma | | Yes | No | AIDS/HIV | | Yes | No |
| Emphysema/COPD | | Yes | No | Hepatitis | | Yes | No |
| Bronchitis | | Yes | No | Sexually transmitted disease | | Yes | No |
| History of Tuberculosis | | Yes | No | OTHER: | | | |
| Active Tuberculosis | | Yes | No | | | | |
| OTHER: | | | | **GASTROINTESTINAL** | | | |
| | | | | **DISORDERS** | | | |
| **NEUROLOGICAL DISORDERS** | | | | G.E Reflux/Heartburn | | Yes | No |
| Epilepsy | | Yes | No | Ulcers/Gastritis | | Yes | No |
| Stroke | | Yes | No | Eating Disorder | | Yes | No |
| Migraine | | Yes | No | Inflammatory Disease | | Yes | No |
| OTHER: | | | | OTHER: | | | |
| | | | | | | | |
| **BEHAVIOR CONDITIONS** | | | | **HORMONAL DISORDERS** | | | |
| Mental Health Disorder | | Yes | No | Diabetes Type I Type II | | Yes | No |
| Anxiety/Panic Attacks | | Yes | No | Recent A1C | | | |
| Controlled Substance Use | | Yes | No | Thyroid Problem | | Yes | No |
| Type: | | | | OTHER: | | | |

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## Consent to Share Confidential Dental Information

**To be valid this form must be filled out COMPLETELY, including**
**What information you are giving us permission to share.**

Patient's Legal Name:_____ Birth Date:_____

**I HEREBY AUTHORIZE HENNIKER FAMILY DENTISTRY TO SHARE:**

- ☐ Any of my medication/dental information
- ☐ Payment and Insurance Information
- ☐ My appointment times, dates and reason for visits
- ☐ The Medications I am taking

**WITH THE FOLLOWING PEOPLE:**

Full Name:_____Relationship_____

Full Name:_____Relationship_____

I understand that I may cancel this consent at any time (by writing to Henniker Family Care), but that cancelling it will not affect any information that has already been released.
I understand that I do not have to sign this form, and that I should only sign it if I want my dental provider or my clinic to share my information with someone.
This authorization expires: When I cancel it in writing _____
Signature:_____Date:_____

Relationship to minor patient (if parent or legal guardian)*_____
If you are not the minor patient's parent, you must give us proof of guardianship (for example: a court order or power of attorney)

Witness:_____Date:_____

# FINANCIAL & APPOINTMENT AGREEMENT FOR FAMILY DENTAL CARE

This agreement is to inform you of your financial obligation to our practice. We are committed to providing you with the most comprehensive dental care using only the highest quality materials and technology available in the market today. We are also committed to providing you with up-to-date information and educational tools so that you may fully participate in maintaining optimum oral health.

All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not your insurance company. Your insurance policy is an agreement between you, your employer, and the insurance company. Our practice is not a party to that agreement. If payment from your insurance company is not received within 60 days from date of service, you will be expected to pay the balance in full.

Your **estimated** copayment for treatment, which is the amount not covered by your insurance, is due at the time treatment is provided. Your **estimated** copayment may be adjusted after time of treatment depending upon the final reconciliation of insurance payments. Our practice accepts, cash, personal checks, Mastercard, Visa, and Discover and Care Credit.

Additionally, our practice will charge you for appointments that you do not keep and for appointments that you do not cancel with in 24 hour notice.

Please do not hesitate to ask if you have any questions regarding this financial agreement. We are committed to providing you with the ultimate experience in dental care.

_____

Print Name of Patient or Responsible Party

_____ _____

Signature of Patient or Responsible Party Date