HEALTH HISTORY

IDALOU DENTAL

Mr. Mrs. Ms. Miss Dr.

Name _____ Date of Birth _____

Home Phone Number _____ Cell Phone Number _____

Address _____ City _____ State _____ Zip _____

Social Security Number _____ Email _____

Employed by _____ Position _____

Referred by _____

Dental Insurance Company _____ Member ID _____

Are you the policy holder? yes no If not, who? _____

Policy Holder DOB _____ Policy Holder SSN _____

Medical History

Are you currently under a physician's care?	yes	no
Are you allergic to penicillin?	yes	no
Are you allergic to latex?	yes	no
Do you have any artificial joints?	yes	no
Do you have an artificial heart valve?	yes	no
Were you born with a congenital heart defect?	yes	no
Have you ever had endocarditis? **(Heart infection)**	yes	no
Have you ever taken bisphosphonates (ex. Fosamax)?	yes	no
Do you use tobacco?	yes	no
Females: Are you pregnant?	yes	no

Please list any medications:

_____
_____
_____
_____
_____
_____

Please list any allergies:

_____
_____
_____
_____

Do you have any of the following:

AIDS/HIV	Cancer	Excessive Bleeding	Radiation	Stroke
Alzheimer's	Chemotherapy	Heart Attack	Osteoporosis	Asthma
Anemia	Chest Pain	Pacemaker	High Blood Pressure	Diabetes
Blood Disease	Epilepsy	Hepatitis	Sinus Troubles	Herpes

Dental History

Date of last dental visit _____ How often do you brush? _____

Are you experiencing discomfort presently? yes no How often do you floss? _____

Have you ever had gum treatments? yes no Do you wear a night guard? yes no

Do your gums bleed? yes no Do you experience dry mouth? yes no

Do you experience jaw pain? yes no

Signature _____ Date _____

HIPAA Consent Form

The undersigned acknowledges receipt of a copy of the current effective Notice of Privacy Practices for this dental office. A copy of this signed, dated document shall be effective as the original. My signature will also serve as a Protected Health Information document should I request treatment or radiographs be sent to other dental offices/facilities in the future.

Patient/patients name/s:

_____

_____

Please list any other parties' names who can have access to your dental health information:

_____

_____

I authorize contact from this office to confirm my appointments, discuss treatment and billing information VIA:

Cell phone ____

Home phone ____

Text message ____

Email ____

(please initial)

Signature _____ Date _____

Idalou Dental
Financial Policy

Thank you for visiting our office. Idalou Dental is **out-of-network** with all dental insurances and as a courtesy claims are filed on behalf of our patients for dental services performed in our office. If certain services are not covered by your insurance, you are responsible for paying what your insurance company does not pay. If this claim is not paid within 60 days, the balance is your responsibility.

The dental insurance relationship is between you and the insurance provider that you have selected through an employer or through a self-plan. It is your responsibility to know your dental insurance plan/benefits. As a courtesy we call to verify insurance before your appointment. Therefore, it is your responsibility as the insurance owner to make sure our office has the correct information on file.

There is no guarantee of benefits from the insurance company until a claim is received and processed by your insurance company. Therefore, benefits quoted to you are only an estimate provided by the insurance representative. For your convenience, we accept checks, cash, Visa, Mastercard, Discover, and American Express**. A 24-hour notice is required for cancellation of your appointment. There may be a cancellation fee charged if 24-hour notice is not given.**

Certain insurance companies (e.g. Delta Dental) will not allow Assignment of Benefits to the providing dentist. This simply means that the insurance check is made out and sent to the patient directly, instead of the providing dentist for services completed. In this situation, the patient will pay all costs up front and the insurance company will directly reimburse the estimated patient portion of services completed. As a courtesy, Idalou Dental will file your dental claim.

Signature_____ Date_____