



## Health Assessment

1. Are any of your teeth sensitive to:  Cold  Heat  Sweets  Biting Pressure  
Comments: \_\_\_\_\_
2. Do you have fluoride in your drinking water?  Yes  No
3. Does your jaw ever feel sore?  Yes  No Do you have TMJ /TMD?  Yes  No
4. Name of Physician: \_\_\_\_\_ Date of last visit: \_\_\_\_\_
5. Have you ever been hospitalized?  Yes  No If yes, please describe: \_\_\_\_\_
6. Have you taken any medicine during the past two years, including prescriptions, over-the-counter meds, vitamins, and herbal supplements?  Yes  No  
If yes, please list: \_\_\_\_\_
7. Are you allergic to or made sick by penicillin, aspirin, codeine, local anesthetics or any other drugs?  Yes  No  
If yes, please list: \_\_\_\_\_
8. Have you ever had a reaction to local anesthetics?  Yes  No
9. Do you have a reaction to metal jewelry or latex?  Yes  No
10. Have you ever had any excessive bleeding requiring special treatment?  Yes  No
11. WOMEN: a. Are you pregnant or are you trying to become pregnant?  Yes  No  
b. Are you nursing?  Yes  No  
c. Are you taking oral contraceptives?  Yes  No
12. Do you smoke or chew tobacco products?  Yes  No
13. Have you ever taken oral or IV Bisphosphonates (Boniva, Fosamax, Actonel, etc.)?  No  Yes Name: \_\_\_\_\_
14. Name of previous dentist: \_\_\_\_\_
15. Have you had orthodontic treatment?  Yes  No If yes, Dr. Name: \_\_\_\_\_
16. What is the main reason for your visit? \_\_\_\_\_
17. Do you like your smile?  Yes  No
18. If you could change anything about your smile what would it be? \_\_\_\_\_

Please check any of the following which you have had or have at present:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Alcohol or Drug Dependency    | <input type="checkbox"/> Diabetes                 | <input type="checkbox"/> Low Blood Pressure                        |
| <input type="checkbox"/> Allergies or Hives            | <input type="checkbox"/> Emphysema or Bronchitis  | <input type="checkbox"/> Medication for Weight Reduction           |
| <input type="checkbox"/> Anemia                        | <input type="checkbox"/> Epilepsy or Seizures     | <input type="checkbox"/> Mental Health Problems                    |
| <input type="checkbox"/> Angina Pectoris               | <input type="checkbox"/> Fainting or Dizzy Spells | <input type="checkbox"/> Persistent Cough                          |
| <input type="checkbox"/> Arthritis or Swollen Joints   | <input type="checkbox"/> Glaucoma                 | <input type="checkbox"/> Pre-Medication for Dental Work            |
| <input type="checkbox"/> Artificial Heart Valve        | <input type="checkbox"/> Heart Disease or Attack  | <input type="checkbox"/> Radiation Therapy                         |
| <input type="checkbox"/> Artificial Joint              | <input type="checkbox"/> Heart Murmur             | <input type="checkbox"/> Rheumatic Fever                           |
| <input type="checkbox"/> Asthma                        | <input type="checkbox"/> Heart Pacemaker          | <input type="checkbox"/> Sexually Transmitted Disease              |
| <input type="checkbox"/> Autoimmune Disease            | <input type="checkbox"/> Heart Surgery            | <input type="checkbox"/> Sickle Cell Disease                       |
| <input type="checkbox"/> Back Problems                 | <input type="checkbox"/> Hemophilia               | <input type="checkbox"/> Sinus Trouble                             |
| <input type="checkbox"/> Birth Control Pills           | <input type="checkbox"/> Hepatitis (Type _____)   | <input type="checkbox"/> Stroke                                    |
| <input type="checkbox"/> Blood Transfusion             | <input type="checkbox"/> High Blood Pressure      | <input type="checkbox"/> Thyroid Problems                          |
| <input type="checkbox"/> Cancer or Chemotherapy        | <input type="checkbox"/> HIV/AIDS                 | <input type="checkbox"/> Tuberculosis/Lung Disease                 |
| <input type="checkbox"/> Cold Sores                    | <input type="checkbox"/> Jaundice                 | <input type="checkbox"/> Ulcers or other Gastrointestinal Problems |
| <input type="checkbox"/> Congenital Heart Defect       | <input type="checkbox"/> Kidney Trouble           |  |
| <input type="checkbox"/> Cortisone Medicine (Steroids) | <input type="checkbox"/> Liver Disease            |  |

Do you have any medical condition or problem not listed above?  Yes  No

If yes, please list: \_\_\_\_\_

To the best of my knowledge, all of these answers are true and correct. If I have any change in my health, or if my medications change, I will inform Howe Dental at or prior to my next appointment.

\_\_\_\_\_  
Signature of Patient or Guardian

\_\_\_\_\_  
Date

Office Use BP: \_\_\_\_\_ Pulse: \_\_\_\_\_ ASA: \_\_\_\_\_ Allergies: \_\_\_\_\_ Pre-Med: \_\_\_\_\_ Initials: \_\_\_\_\_

**Acknowledgement of Receipt of Notice of Privacy Practices**

I acknowledge that I have received a copy of the Notice of Privacy Practices from the office of Chad V. Howe, DDS. The Notice of Privacy Practices describes the type of uses and disclosures of my protected health information that may occur in my treatment, payment for services or in the performance of the office's health care operations. The Notice of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Notice of Privacy Practices is posted in the facility for disclosure.

Howe Dental reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. If there are changes, the office shall provide a copy of the revised Notice of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Notice of Privacy Practices by requesting that one be sent to me.

Name of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_  
 Signature of Patient or Guardian

Self    Mother    Father    Relative    Other:  
 \_\_\_\_\_  
 Relationship to Patient

**Photo Release Form**

I grant permission to Dr. Chad V. Howe and Associates, to use photographs or images taken of me for publication in brochures, promotionals, newsletters, and magazines, and to use the Photos on display boards, website, and to offer them for publications in other publications, without notifying me.

I further agree that Dr. Chad V. Howe and Associates may license others to use the Photo or any excerpts, and my name and likeness used in or identifying the Photos, and in any related or derivative versions of the Photos, and in the advertising, marketing and promotion of the Photos in all media throughout the universe. I agree to waive and release any and all claims against Dr. Chad Howe and Associates and its contractors and licensees relating to my name, my likeness, the Photos and their uses and/or distribution in any version or media throughout the universe, including without limitation, any rights and claims relating to royalties or compensation, editing, alteration, copyright, distribution, misappropriation, libel, false light, rights of privacy and / or publicity.

Name (please print): \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_  
 Signature of Patient or Guardian

Self    Mother    Father    Relative    Other:  
 \_\_\_\_\_  
 Relationship to Patient

### Financial Policy

In our continued commitment to provide the highest quality of dental care to all our patients and to have those services affordable, we are pleased to offer you these financial options and guidelines for payment:

- If you have insurance, we will gladly process your claims. We do require that you pay all estimated patient portions when services are rendered.
- It is the responsibility of the patient to know your individual insurance plan benefits.
- Any outstanding insurance benefits not received by this office within 90 days of date of service will be your responsibility. If you do not have insurance, full payment is expected as services are rendered.
- Every effort will be made to help you with your insurance. The estimated insurance coverage is not a guarantee of payment and the insurance company, not our office, determines the dental benefits you receive. Please keep your insurance information current by notifying us of any changes in employment and insurance coverage.
- For our patients without insurance a 5% cash courtesy will be offered if treatment is paid in full upon date of service.
- For procedures involving a laboratory step (i.e. crowns, dentures, night guards), 50% of the total fee is required before the case will be sent to the lab. Our office uses a high end lab, patients are responsible for all lab fees.
- Fees are guaranteed for 6 months from the date of your financial estimate.
- We accept Visa, MasterCard, Discover, American Express, personal checks, debit cards and cash.
- Financing is available through Care Credit, which offers interest free payment options for large treatment plans. Ask us for an application.
- 48 hours notice is required when re-scheduling or cancelling an appointment. A cancellation fee of \$50 per half-hour will be assessed for any missed appointments.

**Office Goal:** Our office goal is to provide a comprehensive care plan, followed by a preventative maintenance schedule. We strive to present treatment and financial information prior to appointments, therefore eliminating lingering questions. We make every attempt to provide exceptional care in a comfortable environment. **Welcome to our office!**

### Signature

I hereby agree that I am fully responsible for the total payment of all procedures performed in this office. I authorize the dental office to release records to my insurance company as needed for payment of dental benefits. I authorize my insurance benefits, if any, to be paid directly to the dental office.

\_\_\_\_\_  
Signature of Patient or Guardian

\_\_\_\_\_  
Date

**Office Financial Policies**

As a condition of your treatment by this office, financial arrangements must be made in advance. This practice depends upon reimbursement from our patients for the cost incurred in their care to remain viable. Therefore, financial responsibility on the part of each patient must be determined before treatment.

All emergency detail services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are rendered.

Patients who carry dental insurance understand that all dental services finished are charged directly to the patients and that he or she is personally 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 collection 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) on the unpaid balance will be assessed on all accounts exceeding sixty (60) days from the date of service unless previously written financial agreements are made. Financial arrangements will only be accepted in the form of a credit card, which we will charge monthly. There will be a minimum charge of \$2.00 for a balance under \$200. I understand that the fee estimate listed for this dental care can only be extended for a period of six (6) months from the date of patient examination. I also understand that I will be charged for any appointment time that has been reserved for me, or my family if I do not contact your office within 48 hours.

In consideration for the professional services to be rendered to me (or, at my request, to my minor child or ward) by the dentist, I agree to pay the fee charged for the dental services provided by the dentist or licensed employee at the time the services are rendered, or within five (5) days of the billing if credit is extended by the dentist. In the event my account becomes delinquent, I agree to pay the remaining account balance plus the sum of the collection commission (40%) charged by the collection agency to whom a delinquent account is turned for collection, in addition to reasonable attorney fees and court costs where such legal services are necessary. I authorize the release of financial identification information concerning my account, including charges billed, payments made, and interest charges assessed, etc., to the dentist's collection agency or collection attorney should collection procedures become necessary.

I grant my permission to you or your assignee to telephone me at home or my workplace to discuss matters related to this form. I also agree to allow this office to leave messages concerning appointments and/or results on my answering machine or with a family member.

This agreement supersedes all prior agreements signed, including any and all mediation or mediation/arbitration agreements. I acknowledge that any prior mediation or mediation/arbitration agreements signed previously related to financial arrangements or quality of care are null and void.

I authorize the dentist or his designees to release financial identification 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 acknowledge that I have had an opportunity to read the "Office Privacy Policies" as provided by Chad V. Howe. I understand the rights as defined by HIPPA.

I agree to disclose to the dentist names of any individuals with whom I authorize the dentist to discuss my dental care.

**I agree to abide by the conditions outlined herein.**

**Patient Name:** \_\_\_\_\_  
(PLEASE PRINT)

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
(PATIENT, LEGAL GUARDIAN OR AUTHORIZED AGENT OR PATIENT)

**Witness:** \_\_\_\_\_ **Date:** \_\_\_\_\_



**CONSENT TO PROCEED**

I authorize Dr. Howe and/or such associates or assistants as s/he may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation, muscle soreness, and temporary or rarely, permanent numbness. I understand that occasionally needles break and may require surgical retrieval. Occasionally drops of local anesthetic may contact the eyes and facial tissues and cause temporary irritation.

I understand that as part of the dental treatment, including preventive procedures such as cleanings and basic dentistry, including fillings of all types, teeth may remain sensitive or even possibly quite painful both during and after completion of treatment. Dental materials and medications may trigger allergic or sensitivity reactions.

After lengthy appointments, jaw muscles may also be sore or tender. Holding one's mouth open can, in a predisposed patient, precipitate a TMJ disorder. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. Although rare, it is also possible for the tongue, cheek or other oral tissues to be inadvertently abraded or lacerated (cut) during routine dental procedures. In some cases, sutures or additional treatment may be required.

I understand that as part of dental treatment items including, but not limited to crowns, small dental instruments, drill components, etc. may be aspirated (inhaled into the respiratory system) or swallowed. This unusual situation may require a series of x-rays to be taken by a physician or hospital and may, in rare cases, require bronchoscopy or other procedures to ensure safe removal.

I understand the need to disclose to the dentist any prescription drugs that are currently being taken or that have been taken in the past. I understand that taking the class of drugs prescribed for the prevention of osteoporosis, such as Fosamax, Boniva or Actonel, may result in complications of non-healing of the jaw bones following oral surgery or tooth extractions.

I do voluntarily assume any and all reasonable medical/dental risks, including the substantial and significant risk of serious harm, if any, which may be associated with any phase of standard dental preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

Patient Name: \_\_\_\_\_

Signature: \_\_\_\_\_  
(Patient, legal guardian or authorized agent of patient)

Date: \_\_\_\_\_

Witness: \_\_\_\_\_

Date: \_\_\_\_\_