Health History Form

ADA American Dental Association®
America's leading advocate for oral health

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: *Last First Middle*
Home Phone: *Include area code* ( )
Business/Cell Phone: *Include area code* ( )

Address: *Mailing address*
City: State: Zip:

Occupation: Height: Weight: Date of Birth: Sex: M F

SS# or Patient ID: Emergency Contact: Relationship: Home Phone: *Include area code* ( ) Cell Phone: *Include area code* ( )

If you are completing this form for another person, what is your relationship to that person?

Your Name *Relationship*

Do you have any of the following diseases or problems: *(Check DK if you Don't Know the answer to the question)*	**Yes**	**No**	**DK**
Active Tuberculosis	☐	☐	☐
Persistent cough greater than a 3 week duration	☐	☐	☐
Cough that produces blood	☐	☐	☐
Been exposed to anyone with tuberculosis	☐	☐	☐

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**
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐
Do you drink bottled or filtered water?	☐	☐	☐
If yes, how often? (*Check one:*) DAILY☐ / WEEKLY ☐ / OCCASIONALLY ☐			
Are you currently experiencing dental pain or discomfort?	☐	☐	☐

	Yes	**No**	**DK**
Do you have earaches or neck pains?	☐	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Do you brux or grind your teeth?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Do you participate in active recreational activities?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐

Date of your last dental exam:
What was done at that time?

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**
Are you now under the care of a physician?	☐	☐	☐

Physician Name: Phone: *Include area code* ( )

Address/City/State/Zip:

Are you in good health?	☐	☐	☐
Has there been any change in your general health within the past year?	☐	☐	☐

If yes, what condition is being treated?

Date of last physical exam:

	Yes	**No**	**DK**
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐	☐

If yes, what was the illness or problem?

Are you taking or have you recently taken any prescription or over the counter medicine(s)?	☐	☐	☐

If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements:

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)

	Yes	No	DK
Do you wear contact lenses?	☐	☐	☐
Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	☐	☐	☐
Date: _____ If yes, have you had any complications? _____			
Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax®, Actonel®, Atelvia, Boniva®, Reclast, Prolia) for osteoporosis or Paget's disease?	☐	☐	☐
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?	☐	☐	☐
Date Treatment began: _____			

	Yes	No	DK
Do you use controlled substances (drugs)?	☐	☐	☐
Do you use tobacco (smoking, snuff, chew, bidis)?	☐	☐	☐
If so, how interested are you in stopping? *Circle one:* VERY / SOMEWHAT / NOT INTERESTED			
Do you drink alcoholic beverages?	☐	☐	☐
If yes, how much alcohol did you drink in the last 24 hours? _____			
If yes, how much do you typically drink i n a week? _____			
WOMEN ONLY Are you:			
Pregnant?	☐	☐	☐
Number of weeks: _____			
Taking birth control pills or hormonal replacement?	☐	☐	☐
Nursing?	☐	☐	☐

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

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

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

	Yes	No	DK
Artificial (prosthetic) heart valve	☐	☐	☐
Previous infective endocarditis	☐	☐	☐
Damaged valves in transplanted heart	☐	☐	☐
Congenital heart disease (CHD)			
Unrepaired, cyanotic CHD	☐	☐	☐
Repaired (completely) in last 6 months	☐	☐	☐
Repaired CHD with residual defects	☐	☐	☐

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

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

	Yes	No	DK
Autoimmune disease	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Systemic lupus erythematosus	☐	☐	☐
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐
Tuberculosis	☐	☐	☐
Cancer/Chemotherapy/ Radiation Treatment	☐	☐	☐
Chest pain upon exertion	☐	☐	☐
Chronic pain	☐	☐	☐
Diabetes Type I or II	☐	☐	☐
Eating disorder	☐	☐	☐
Malnutrition	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
G.E. Reflux/persistent heartburn	☐	☐	☐
Ulcers	☐	☐	☐
Thyroid problems	☐	☐	☐
Stroke	☐	☐	☐

	Yes	No	DK
Glaucoma	☐	☐	☐
Hepatitis, jaundice or liver disease	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Neurological disorders	☐	☐	☐
If yes, specify: _____			
Sleep disorder	☐	☐	☐
Do you snore?	☐	☐	☐
Mental health disorders	☐	☐	☐
Specify: _____			
Recurrent Infections	☐	☐	☐
Type of infection: _____			
Kidney problems	☐	☐	☐
Night sweats	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistent swollen glands in neck	☐	☐	☐
Severe headaches/ migraines	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
Excessive urination	☐	☐	☐

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ☐ ☐ ☐

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? ☐ ☐ ☐
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:

GLOBAL DENTAL GROUP
Dr.Murat ATLI DDS
PATIENTS WITH DENTAL INSURANCE

ALL THIS INFORMATION IS NECESSARY TO VERIFY YOUR DENTAL COVERAGE!!

Name of insured_____Insured SS#_____

Adress of insured _____Insured Date of Birth _____

Employer_____

Dental Insurance Company Name _____

ID/Policy Number _____Insurance Com.Phone(___)_____

Medical insurance name: _____

ID/Policy Number_____

Relationship to Insured person: Self _____Spouse _____ Child _____

ASSIGNMENT AND RELEASE

I, undersigned, certify that (or my dependent have insurance coverage and assign directly to _____, DDS all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payments of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: _____

Relationship to insured: Self _____Spouse _____ Child _____

Medical Records Release Form

By signing this form, I authorize my health care provider/hospital_____ to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the dental provider listed below.

Patient Full Name (Print Last Name, Middle, First): _____

Date of Birth: _____

The information you may release subject to this signed to this signed medical release form is as follows:

- ☒ Entire Medical Record (2 years)
- ☐ Medication Record
- ☐ Hospital Reports
- ☐ Radiology Reports
- ☐ Personal Health Profile
- ☐ Progress Notes

Release my protected health information to the following physician/facility and/or those directly associated in my medical care:

Name: _____

Address: _____

- ☐ Mail to Address Listed Above: _____
- ☒ Fax Number/Attention: _____

The purpose/reason for this release of information is as follows: Optimize dental care. _____

_____

Signature of Patient/Personal Representative: _____ Date: _____

Review Of System (ROS)

Patient Name:_____
Patient D.O.B:_____
Date:_____

Have you ever had, or do you now have any of the conditions listed?

I . Skin

Itching _____Yes_____NO _____

Rash _____Yes_____NO _____

Ulcers _____ Yes_____NO _____

Pigmentations _____Yes_____NO _____

Lack of loss of body hair ____Yes_____NO _____

II. Eyes

Blurring of vision_____Yes_____NO_____

Double vision_____Yes_____NO_____

Drooping of eyelids_____Yes_____NO_____

Glaucoma_____Yes_____NO_____

III. Extremities

Varicose veins _____Yes_____NO_____

Swollen, painful joints _____Yes_____NO_____

Muscles weakness, pain ____Yes_____NO_____

Bone deformity, fracture____Yes_____NO_____

Prosthetic joints_____Yes_____NO_____

IV. Ear, Nose, Throat

Earache_____Yes_____NO _____

Hearing loss_____Yes_____NO _____

Frequent nosebleeds ____Yes_____NO _____

Hoarseness_____Yes_____NO_____

V. Respiratory

Cough, blood in sputum___Yes_____NO_____

Emphysema, bronchitis____Yes_____NO_____

Wheezing, asthma_____Yes_____NO_____

Tuberculosis, exposure to___Yes_____NO_____

VI. Cardiac

Shortness of breath_____Yes_____NO_____

Pain, pressure in chest_____Yes_____NO_____

Swelling of ankles_____Yes_____NO_____

High, low blood pressure____Yes____NO_____

Rheumatic, scarlet fever_____Yes____NO_____

Heart murmur, attack_____Yes_____NO_____

Prosthetic valves/pacemakers_Yes_____NO_____

Patient Signature: _____

Doctor Sign: _____

NPI#_____ TAX ID#_____

VII. Gastrointestinal

Difficulty swallowing _____Yes_____NO_____

Abdominal pain, ulcers _____Yes_____NO_____

Hepatitis, jaundice_____Yes_____NO_____

Liver disease _____Yes_____NO _____

VIII. Genitourinary

Difficulty, pain on urination _____Yes_____NO _____

Blood in urine_____Yes_____NO_____

Excessive urination_____Yes_____NO_____

Kidney infections_____Yes_____NO_____

Sexually transmitted disease_____Yes_____NO_____

IX. Endocrine

Thyroid trouble_____Yes_____NO_____

Weight change_____Yes_____NO_____

Diabetes_____Yes_____NO_____

Excessive thirst_____Yes_____NO_____

X. Hematopoietic

Easy bruising, excessive bleeding__Yes_____NO _____

Persistent lymphadenopathy _____Yes_____NO _____

G6PD deficiency _____Yes_____NO _____

Anemia _____Yes_____NO _____

HIV infection, AIDS _____Yes_____NO_____

Leukemia, problems with immune system _Yes___NO_____

Spleen problems _____Yes_____No_____

XI. Neurologic

Frequent headaches _____Yes_____NO_____

Dizziness, fainting _____Yes_____NO_____

Epilepsy, fits _____Yes_____NO_____

Neuritis, neuralgia _____Yes_____NO_____

Paresthesia, numbness _____Yes_____NO_____

Paralysis _____Yes_____NO_____

XII. Psychiatric

Nervousness _____Yes_____NO_____

IIrritability_____Yes_____NO_____

Depression, excessive worry ____Yes_____NO_____

Nervous breakdown_____Yes_____NO_____

Date: _____

New Era Consulting
Specializing in Medical Billing for Dentists

Patient Name:

Patient DOB:

Date:

Epworth Sleepiness Scale Questionnaire

This questionnaire was developed based upon the published findings of the American Academy of Sleep Medicine (AASM). The purpose of this questionnaire is to aid a qualified medical professional in identifying possible symptoms of a sleep disorder and is not meant to be used as a substitute for any diagnostic procedure.

1. Have you ever been told you stop breathing while asleep?	Y / N	8
2. Have you ever fallen asleep or nodded off while driving?	Y / N	6
3. Have you ever woken up suddenly with shortness of breath, gasping or with your heart racing?	Y / N	6
4. Do you feel excessively sleepy during the day?	Y / N	4
5. Do you snore, or have you ever been told that you snore?	Y / N	4
6. Do you have trouble falling asleep?	Y / N	4
7. Do you have trouble staying asleep once you fall asleep?	Y / N	4
8. Do you kick or jerk your legs while sleeping?	Y / N	3
9. Do you feel burning, tingling or crawling sensations in your legs when you wake up?	Y / N	3
10. Do you wake up with headaches during the night or in the morning?	Y / N	3
11. Have you had weight gain and found it difficult to lose?	Y / N	2
12. Have you taken medication for, or been diagnosed with high blood pressure?	Y / N	2
Total Score		

For Doctor/Staff Use Only

Low	Moderate	High	Severe
0-7	8-11	12-15	16+

Visual Indications

☐ Enlarged/Scalloped Tongue ☐ Retruded Lower Jaw ☐ High Arching Hard Palate ☐ Bruxism

☐ Gastroesophageal Reflux ☐ Enlarged Tonsils ☐ Mouth Breather

Have you ever been diagnosed with a sleep disorder? Yes or No

Are you currently using a CPAP machine? Yes or No (if yes) Do you use it every night? Yes or No

Notes:

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Dr.Murat ATLI DDS

Consent to Use and Disclosure of Health Information for Treatment, Payment or Healthcare Operations

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of health care professionals

I understand and have been provided with a ***Notice of Information Practices*** that provides a more complete description of information uses and disclosures. I understand that I have the right to revied the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right the request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to extent that the organization has already taken action in reliance thereon.

This is my written permission that the following people have access to my healthcare information:

_____

_____

_____

Signature of Patient or Legal Representative Witness

Patient Signature _____ Date _____

Parent or Guardian Signature if Minor Patient _____

GLOBAL DENTAL GROUP
Dr.Murat ATLI DDS
Practice Policy

We are honored that you have chosen us to provide your dental care. We are here to serve your dental needs and below are some general guidelines for our office:

General:

- Office hours Monday through Thursday 9:00 am to 6:00pm and we are closed for lunch from 1:00-2:00. We have Oral surgery dates on select Fridays of each month and these are by appointment only.
- We do ask for notification of any appointment changes to be made directly with a staff member 24 hours prior to scheduled appointment time. We do not accept changes on our voicemail, text or email systems.
- As a courtesy to you, all appointments will receive a call 2 days prior to the scheduled time. We do ask that you make any changes to your contact information or insurance at this time to help us better expedite your appointment.

Payments:

- We accept most major credit cards including American Express, Mastercard, Visa and Discover.
- For your convenience, our office also offers flexible monthly payment plans. There are also interest free plans available up to 12 months.
- Payments for services are to be paid at the time that the services are rendered. Insurance is filled as a courtesy for our patients and balances are responsibility of the insured.

Insurance:

- To better assist you, we require all insurance information and verification 48 hours prior your appointment time.
- Full payment at the time of service will be required when less than 48 hours' notice to insurance charges are not completed. We will file insurance for this appointment to have you directly reimbursed.

Patient Signature _____ Date _____

Parent or Guardian Signature if Minor Patient_____

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No Show and Cancellation Policy

- We require 24 business hours for any appointment changes.
- Cancellations within 24 business hours of appointment will be charge fee of $75 per hour of appointment time. Please note that we aware that emergencies do arise, and we are willing to work with you if such circumstances occur.
- "No Show "appointments will be treated the same as a same day cancellation and therefore are subject to the $75 per our fee.

Our office will make every effort to contact you regarding your pre-scheduled time so that we can work together to avoid any charges to your account. Please be sure to provide 2 contact numbers to reach you to help assist us in contacting you. We appreciate your help and look forward serving your dental needs.

Patient Signature _____ Date _____

Parent or Guardian Signature if Minor Patient_____

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Dr.Murat ATLI DDS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

(You may refuse to sign this acknowledgement)

I, _____, have received a copy of this office's Notice of Privacy Practice.

Please Print Signature: _____

Patient Signature _____ Date _____

Parent or Guardian Signature if Minor Patient_____

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For Office Use Only

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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
□ Communications barriers prohibited obtaining the acknowledgement
□ An emergency prevented us from obtaining acknowledgement
□ Other (Please Specify):

_____

_____

GLOBAL DENTAL GROUP
Dr.Murat ATLI DDS

Insurance and Financial Policies

Thank you for choosing our office for your dental needs. We would like to make you aware of some changes to our Insurance and Financial policies. We strive to maintain quality dentistry with compassion and in a comfortable and friendly environment. We hope that you and your family will feel welcome in our office.

Since we know it is not always possible to pay your dental bill in full, we would like to explain our financial options:

Dental Insurance: If you have dental insurance, as a courtesy to you, we will verify your dental insurance policy and submit your claims to the insurance company. We ask that you pay the estimated co-payment at the time services are rendered. If you fail to bring the required insurance information to your appointments, we will ask that you pay the bill in full and reimbursed from your insurance company with paperwork provided by our office. Our office does not guarantee that your insurance company will [ay for the treatment you receive from our practice. If your claim is denied or the treatment is down coded and or alternative benefits given, you will be responsible for paying the full balance amount left on the account at that time. _____(initials)

Our office will not enter into a dispute with your insurance company over any claim, although we will provide the necessary documentation your insurance company requests to settle the claim.

If your insurance company has not made a payment within 90 days of billing, the balance will become your responsibility. (Insurance coverage is a contractual agreement between the insurance company and you or your employer. We have no control over this relationship.)

Payment is due at the time treatment is rendered. We accept Cash, Personal checks, credit and debit cards, CareCredit and HAS/Flex cards.

If you need to make long-term payments, we can offer financing through CareCredit up to 12 months. Also, Icare up to 48 months. Any financial agreements will need to be completed before treatment is rendered.

All patients with and outstanding balance will receive a statement each month. There is a finance charge of 1.5% (18% APR) on all accounts 60 days overdue. If you have returned check you will be charged a return check fee of $50.00/ check in addition to any fees your bank charges.
_____(Initials)

We reserve the right to charge for appointments broken without proper 24 business hours' notice. There is minimum fee of $75 per hour scheduled.

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MINOR PATIENTS: The adult accompanying the minor is responsible for the payment on the account. For unaccompanied minors, non-emergency treatment will be denied unless charged have been pre-authorized to an approved credit plan, a MC/Visa, check or cash payment is paid on the account at the time of service.

I authorize and release information and payment of my dental insurance to the dentist.

I have read and understand fully the financial options. I agree to accept responsibility for payment of my bill including co-pays, deductibles or non-covered services requested by me. I understand that in the event my account becomes delinquent I will be responsible for any collections, attorney fees, court costs, interest and any other charges incurred to collect this account. In the event that the account is turned over to collections you will need to discuss all payment arrangements with the collection agency.

Please Print Signature:

_____

Patient Signature _____ Date _____

Parent or Guardian Signature if Minor Patient _____