

# SofTouch Dental Care Patient Information and Health Questionnaire

Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex: Male Female  
 Name you prefer our team to address you by: \_\_\_\_\_ Status: Single Married Child < 18 Other: \_\_\_\_\_

**Whom may we thank for referring you to our office?** \_\_\_\_\_

Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Number/Street City/State Zip

Business Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ E-mail address \_\_\_\_\_

Please circle preferred method of contact: Home phone Business Phone Cell phone E-mail

Employer: \_\_\_\_\_

Spouse or Responsible Party to Child/Patient Name: \_\_\_\_\_

Business Phone: \_\_\_\_\_ Employer: \_\_\_\_\_ E-mail address \_\_\_\_\_

Person to contact in case of emergency: \_\_\_\_\_ Phone: \_\_\_\_\_

## Medical History

**We are interested in your total health. Please pay close attention to our health questions so that we may be of better service to you.**  
 Please circle any of the following, which apply to you

- |                                     |                            |                             |                        |
|-------------------------------------|----------------------------|-----------------------------|------------------------|
| Heart Disease/Attack                | Headaches (persistent)     | A.I.D.S. (HIV positive)     | Stroke                 |
| Angina Pectoris                     | Emphysema                  | Hepatitis A                 | Muscular Dystrophy     |
| High Blood Pressure                 | Persistent Cough           | Hepatitis B                 | Multiple Sclerosis     |
| Low Blood Pressure                  | Tuberculosis               | Liver Disease               | Bleeding Disorders     |
| Heart Murmur                        | Asthma                     | Chemical Dependency         | Glaucoma               |
| Rheumatic Fever                     | Hay Fever                  | Hemophilia                  | Speech Impediment      |
| Congenital Heart Defects            | Sinus Trouble (Infections) | Venereal Disease            | Anemia                 |
| Scarlet Fever                       | Allergies or Hives         | Cold Sores (Fever Blisters) | Arthritis (Rheumatism) |
| Artificial Heart Valve              | Diabetes                   | Epilepsy or Seizures        | Hearing Problems       |
| Pacemaker                           | Thyroid Problems           | Fainting or Dizzy Spells    | Pregnant-Month _____   |
| Heart Surgery                       | Cancer or Tumors           | Nervous Disorders           | Breast feeding         |
| Artificial Joints (Hip, Knee, etc.) | Radiation Treatment        | Psychiatric Treatment       | Birth Control          |
| Blood Transfusion (s)               | Chemotherapy               | Lupus Erythematosus         | Gum Tissue Recession   |
| Tooth Cold Sensitivity              |                            |                             |                        |

### Are you aware of being allergic to or have you ever reacted adversely to any of the following?

Penicillin or other Antibiotics Codeine or other Narcotics Barbiturates or Sedatives Latex  
 Aspirin, Ibuprofen, Aleve Local Anesthetics (Xylocaine) Nitrous Oxide  
 Other: \_\_\_\_\_

**Do you currently take pre-medication before dental visits? Yes No**

Are you currently under a physician's care: Yes No  
 If yes: Condition (s) being treated: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Are you currently taking any medication, drugs, or pills Yes No  
 If yes, please list medications and dosage? \_\_\_\_\_

Are you presently taking Aspirin, Ibuprofen, Aleve or Herbal Medications? Yes No  
 If yes, please list what you take and for what reason: \_\_\_\_\_

Do you have any bone problems? ie: Osteoporosis? Yes No  
If yes, do you take Bisphosphonates? Yes No Which one? Fosamax Actonel Boniva

Do you have any history of: TMJ Problems Yes No  
Jaw clicking or cracking? Yes No  
Limited jaw opening? Yes No

If yes, what type of treatment have you had in the past for this condition? \_\_\_\_\_

Do you have any disease, condition, or problem not listed? Yes No  
If yes, please explain, \_\_\_\_\_

**Dental Insurance Information:**

Insured's Name \_\_\_\_\_ Insured's ID/SS # \_\_\_\_\_ Birth date \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Insurance Company Address \_\_\_\_\_ Phone: \_\_\_\_\_  
Number/Street City/State Zip

Secondary Insured's Name \_\_\_\_\_ Insured's ID/SS# \_\_\_\_\_ Birth date \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Insurance Company Address \_\_\_\_\_ Phone: \_\_\_\_\_  
Number/Street City/State Zip

**Consent:**

1. I understand the above information is necessary to provide patients with dental care in a safe and efficient manner.
2. I have answered all questions truthfully and to the best of my knowledge. I agree to notify the doctor of any changes at subsequent visits.
3. I authorize the doctor to obtain x-rays, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the patient's needs. I consent to be photographed before, during, and after treatment. These photographs shall remain property of SofTouch Dental Care and may be published in dental journals, office manuals and/or shown for education purposes. I understand that my first name may be used with these photos for identification purposes.
4. I will be given the opportunity to discuss my treatment plan with the doctor prior to beginning any treatment.
5. I give my consent for the dental treatment, medication, or therapy indicated on my treatment plan and any other treatment deemed advisable as a corollary to this treatment plan.
6. I understand that all information on this patient information form will be held in strict confidence and in accordance with all HIPPA rules and regulations.
7. I understand this practice has a 48-hour appointment cancellation policy. In addition the practice needs to be able to effectively contact each patient. I understand that this practice must receive my appointment confirmation **one working day** in advance or my appointment time will be offered to another patient. I understand I will receive a courtesy message to reschedule my appointment.

If a **second** late notice cancellation occurs this office reserves the right to charge my account a \$25.00 per half hour rescheduling fee in addition to payment in full of the scheduled treatment should I choose to remain a patient.

**Financial Responsibility:**

In accordance with the Federal Truth-in-Lending Act the following policies apply in our office:

1. Payment is due at the time treatment is rendered or by previous financial arrangements.
2. In the event my insurance company does not cover the entire balance of my account within 30 days from treatment date, I agree to pay the balance in full within 60 days of treatment date or by previous financial arrangements
3. There is a forty dollar (\$40) charge on all returned checks.
4. In the event of default, I agree to pay legal interest on the indebtedness, any collection costs, and related attorney's fees.

**Patient/Responsible Party Signature:** \_\_\_\_\_

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

