

PATIENT INFORMATION

DATE _____

NAME _____ MALE FEMALE MARRIED SINGLE MINOR
LAST FIRST M

ADDRESS _____
STREET CITY STATE ZIP

BIRTH DATE _____ E-MAIL ADDRESS _____
MONTH DAY YEAR

TELEPHONE _____
HOME WORK CELL PHONE

PLACE OF EMPLOYMENT _____ SS# _____

IF FULL TIME STUDENT, SCHOOL NAME _____ GRADE _____

DENTAL INSURANCE CO. _____ SUBSCRIBER # _____ GROUP # _____

Has any member of your family ever been treated in our office? YES NO

Whom may we thank for referring you to our office? _____

FAMILY INFORMATION

FILL IN BOTH BLOCKS FOR MINOR CHILD,
FILL IN APPROPRIATE BLOCK FOR ADULT

FATHER/HUSBAND	PATIENT HERE	YES	NO	MOTHER/WIFE	PATIENT HERE	YES	NO
LAST _____	FIRST _____		M _____	LAST _____	FIRST _____		M _____
STREET _____	CITY _____	STATE _____	ZIP _____	STREET _____	CITY _____	STATE _____	ZIP _____
HOME TELEPHONE # _____	WORK TELEPHONE # _____			HOME TELEPHONE # _____	WORK TELEPHONE # _____		
BIRTH DATE (MO/DAY/YEAR) _____	SS# _____			BIRTHDATE (MO/DAY/YEAR) _____	SS# _____		
EMPLOYER _____				EMPLOYER _____			
DENTAL INSURANCE CO _____	SUBSCRIBER # _____	GROUP # _____		DENTAL INSURANCE CO _____	SUBSCRIBER# _____	GROUP# _____	

PERSON TO CONTACT IN CASE OF EMERGENCY

OUTSIDE OF IMMEDIATE FAMILY/HOUSEHOLD

NAME _____

ADDRESS _____

CITY/STATE/ZIP _____

TELEPHONE# _____

AUTHORIZATION

I hereby authorize payment directly to the Dental Office of the group Insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals.

X _____
 ADULT PATIENT FATHER/HUSBAND GUARDIAN MOTHER/WIFE

PERSON RESPONSIBLE FOR ACCOUNT

PLEASE CHECK ONE

- PATIENT FATHER/HUSBAND
- GUARDIAN MOTHER/WIFE

METHOD OF PAYMENT

- PAYMENT IN FULL AT EACH APPOINTMENT (CASH/CHECK)
- PAYMENT IN FULL AT EACH APPOINTMENT (VISA/MC)
CARD# _____ EXP DATE _____
- I WISH TO DISCUSS THE DENTAL OFFICE'S FINANCIAL POLICY

SERVICE CHARGE

If I do not pay the entire new balance within 25 days of the monthly billing date, a service & billing charge will be added to the account for current monthly billing period. The service charge will be a periodic rate of 1.5% per month which is an annual percentage rate of 18% applied to the last month's balance. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

DATE _____

DENTAL HISTORY



STEVEN C. HOLLAR, DDS
CHARLES A. HOLLAR, DDS
BETH R. SCHWENN, DDS
574-267-8466

Patient Name
Patient Account No.
Medical Alert

Welcome! So that we may provide you with the best possible care please complete both sides of this medical/dental history form. All information is completely confidential.

What is the reason for your visit today? _____

Date of Last Dental Visit _____ Last Dental Cleaning _____ Last Full Mouth X-rays _____
 What was done at your last dental visit? _____

Previous Dentist's Name _____
 Address _____ State _____ Zip _____
 Telephone _____

How often do you have dental examinations? _____
 How often do you brush your teeth? _____ How often do you floss? _____
 What other dental aids do you use? (Interplak, toothpick, etc.) _____

Do you have any dental problems now? Yes No
 If yes, please describe: _____

Are any of your teeth sensitive to:

Hot or cold?	Yes	No
Sweets?	Yes	No
Biting or Chewing?	Yes	No
Have you noticed any mouth odors or bad tastes?	Yes	No
Do you frequently get cold sores, blisters or any other oral lesions?	Yes	No

Do your gums bleed or hurt?

Have your parents experienced gum disease or tooth loss?	Yes	No
Have you noticed any loose teeth or change in your bite?	Yes	No
Does food tend to become caught in between your teeth?	Yes	No

If yes, where? _____

Do you:

Clench or grind your teeth while awake or asleep?	Yes	No
Bite your lips or cheeks regularly?	Yes	No
Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails)	Yes	No
Mouth breathe while awake or asleep?	Yes	No
Have tired jaws, especially in the morning?	Yes	No
Smoke/chew tobacco?	Yes	No

Have you ever had:

Orthodontic treatment?	Yes	No
Oral surgery?	Yes	No
Periodontal treatment?	Yes	No
Your teeth ground or the bite adjusted?	Yes	No
A bite plate or mouth guard?	Yes	No
A serious injury to the mouth or head?	Yes	No

If so, please describe, including cause _____

Have you experienced:

Clicking or popping of the jaw?	Yes	No
Pain? (joint, ear, side of face)	Yes	No
Difficulty in opening or closing the mouth?	Yes	No
Difficulty in chewing on either side of the mouth?	Yes	No
Headaches, neckaches or shoulder aches?	Yes	No
Sore muscles (neck, shoulders)?	Yes	No

Are you satisfied with your teeth's appearance?

Would you like to keep all of your teeth all of your life?	Yes	No
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Do you feel nervous about having dental treatment? Yes No
 If so, what is your biggest concern? _____

Have you ever had an upsetting dental experience? Yes No
 If yes, please describe _____

Is there anything else about having dental treatment that you would like us to know? Yes No
 If yes, please describe _____

MEDICAL HISTORY



STEVEN C. HOLLAR, DDS
CHARLES A. HOLLAR, DDS
BETH R. SCHWENN, DDS
574-267-8466

1. Have you been under the care of a medical doctor during the past 2 years?..... Yes No
 If yes, for what? _____
 Physician's Name _____ Phone _____
 Address _____ City _____ State _____ Zip _____
2. Have you taken any medication or drugs during the past 2 years?..... Yes No
3. Are you taking any medication, drugs or pills now, including regular dosages of aspirin?..... Yes No
 If yes, please list name and dosage _____
4. Have you ever taken prescription medications for weight loss (diet pills)?..... Yes No
5. Are you aware of having an allergic (or adverse) reaction to any medication or substance?..... Yes No
 If yes, please list: _____
6. Have you been a patient in the hospital during the past five years?..... Yes No
7. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Heart (Surg., Disease, Attack) Yes No	Ulcers..... Yes No	Hepatitis A (infectious) B (serum).. Yes No
Chest Pain..... Yes No	Diabetes.....Yes No	Veneral Disease..... Yes No
Congenital Heart Disease..... Yes No	Thyroid Problems... Yes No	A.I.D.S..... Yes No
Heart Murmur..... Yes No	Glaucoma..... Yes No	H.I.V. Positive..... Yes No
High Blood Pressure..... Yes No	Contact Lenses..... Yes No	Cold Sore/Fever Blisters..... Yes No
Mitral Valve Prolapse..... Yes No	Emphysema..... Yes No	Blood Transfusion..... Yes No
Artificial Heart Valve..... Yes No	Chronic Cough..... Yes No	Hemophilia..... Yes No
Heart Pacemaker..... Yes No	Tuberculosis..... Yes No	Sickle Cell Disease..... Yes No
Rheumatic Fever..... Yes No	Asthma..... Yes No	Bruise Easily..... Yes No
Arthritis/Rheumatism..... Yes No	Hay Fever..... Yes No	Liver Disease..... Yes No
Cortisone Medicine..... Yes No	Latex Sensitivity..... Yes No	Yellow Jaundice..... Yes No
Swollen Ankles..... Yes No	Allergies or Hives... Yes No	Neurological Disorders..... Yes No
Stroke..... Yes No	Sinus Trouble..... Yes No	Epilepsy or Seizures..... Yes No
Diet (Special Restrictions) Yes No	Radiation Therapy.. Yes No	Fainting or Dizzy Spells..... Yes No
Artificial Joints (hip,knee,etc) .. Yes No	Chemotherapy..... Yes No	Nervous/Anxiety..... Yes No
Kidney Trouble..... Yes No	Tumors..... Yes No	Psychiatric/Psychological Care..... Yes No
8. Do you use more than 2 pillows to sleep?.....Yes No
9. Have you lost or gained more than 10 pounds in the past year?.....Yes No
10. Do you have or have you had any disease, condition, or problem not listed?.....Yes No
11. **Women:** Are you: **Pregnant:** Yes__Months No **Nursing?** Yes No **Taking birth control pills?** Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health or medication.

Patient/Guardian Signature _____ Date _____

History Review

Dentist Signature

Date

**ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES
AND
CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION**

TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Dental Health P.C.

Address: 904 S. Union St. Warsaw, IN 46580.

www.DentalHealthpc.com

Telephone: 574-267-8466

Fax: 574-267-8389

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations. I have reviewed a copy of this office's Notice of Privacy Practices.

Patient's Signature: _____ **Date:** _____

If this Consent is signed on behalf of the patient, complete the following:

Representative's Name: _____ **Relationship to Patient:** _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

A COPY OF OUR PRIVACY PRACTICES IS AVAILABLE ON OUR WEBSITE.

For Office Use Only

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 situation prevented us from obtaining acknowledgement
- Other (Please specify) _____