**MEDICAL HISTORY FORM Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City/State/Zip Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-mail \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex **M / F** Height \_\_\_\_\_\_\_ Weight \_\_\_\_\_\_\_ Single / Married

Name of Spouse \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ Closest Relative \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you are completing this form for another person, Referred by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

what is your relationship to that person? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*For the following questions, circle* YES or NO*, whichever applies. Your answers are for our records only and will be considered confidential. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health.*

1. My last physical examination was on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Are you now under the care of a physician(s)? Yes No

If so, what is the condition being treated? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. The name and address of my physician(s) is \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. Have you had any serious illness, operation, or been hospitalized in the past 5 years? Yes No

If so, what was the illness or problem? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**5. Have you ever had joint replacement / pin placement? Yes No** Describe with date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**6. Do you have surgically placed systemic pulmonary *shunts*?** Yes No

7. Are you taking any medicine(s) including non-prescription or herbal? Yes No

If so, what medicine(s) are you taking? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

8. Do you have any history of tobacco/alcohol use? Yes No

9. Do you have or have you had any of the following diseases or problems?

**Y N a. Damaged heart valves / artificial heart valves, including heart murmur or rheumatic heart disease**

**Y N b. Cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke)**

**Y N c. Cardiac pacemaker**

**Y N** d. Allergy, asthma or hay fever

**Y N** e. Sinus trouble

**Y N** f. Fainting spells or seizures

**Y N** g. Diabetes

**Y N** h. Hepatitis, jaundice or liver disease

**Y N** I. AIDS or HIV infection

**Y N** j. Thyroid problems

**Y N** k. Respiratory problems, emphysema, bronchitis, etc.

**Y N** l. Kidney trouble

**Y N** m. Tuberculosis

**Y N** n. Persistent cough or cough that produces blood

**Y N** o. Persistent swollen glands in neck

**Y N** p. Sexually transmitted disease

**Y N** q. Epilepsy or other neurological disease

**Y N** r. Cancer

**Y N** s. Problems of the immune system

**Y N** t. Abnormal bleeding

**Y N** u. Blood transfusion

**Y N** v. Blood disorder such as anemia

**Y N** w. Treatment for a tumor or growth

**Y N x. Osteoporosis/Bone related drugs i.e. Fosamax – Boniva or other bisphosphonates.**

10. Are you allergic or have you had a reaction to:

**Y N** a. Local anesthetics

**Y N** b. Penicillin or other antibiotics

**Y N** c. Sulfa drugs

**Y N** d. Barbiturates, sedatives, or sleeping pills

**Y N** e. Aspirin

**Y N** f. Codeine or other narcotics

**Y N** g. Latex

1. Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

11. Any serious trouble with any previous dental treatment? Yes No

12. Do you have any disease, condition, or problem not listed that you think we should know about? Yes No

If so, explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

13. Are you wearing removable dental appliances? Yes No

# Women

14. Are you pregnant? Yes No

15. Are you nursing? Yes No

16. Are you taking birth control pills? Yes No

**REASON FOR THIS VISIT** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*I certify that I have read and understand the above. I acknowledge that my questions, if any, about the 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 errors or omissions that I may have made in the completion of this form.*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient or parent if patient is a minor

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Doctor Signature**

***Amesbury Dental Associates***

41 Sparhawk Street

Amesbury, MA 01913

(978)388-3505

**GENERAL INFORMED CONSENT FOR TREATMENT**

Dear Patient,

Welcome to our practice and thank you for trusting us with your dental care. Please read the following and sign below:

1. In order to establish a comprehensive plan for treatment certain diagnostic procedures may be performed including, but not limited to: x-rays, clinical examination, photographs and/or impressions of your jaws.
2. Before starting any comprehensive treatment, the risks and benefits of the procedures will be thoroughly explained to you by the doctor and/or staff. We will answer any questions you might have.
3. Please be advised that the practice of dental medicine is not an exact science and that the outcome of the treatment provided depends upon your compliance with keeping scheduled appointments, oral hygiene, recall visit, home care and dietary instructions.
4. Should any changes to the initial treatment plan occur you will be informed of it before hand. The most common occurrences which cause major changes in the dental treatment are:
5. Additional periodontal (gum) treatment.
6. Changes in the materials used.
7. The need for root canal treatment, oral surgery or orthodontic treatment.
8. All fees, co-payments & deductibles are due the day that the service is provided.

My signature below represents my acknowledgement that I have understood the above information and I consent to any necessary diagnostic procedures prior to initiation of dental treatment.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature (parent if minor) Date

**Amesbury Dental Associates**

**41 Sparhawk Street**

**Amesbury, MA 01913**

**(978) 388-3505**

Please read and sign this statement before we agree to accept assignment directly from your insurance company. This avoids any misunderstandings and facilitates processing of your insurance claim. If you have any questions, please ask us. Thank you.

I understand and agree that I am responsible for the payment of all treatment fees on my account. If my insurance company fails to make payment within 90 days, I will be responsible for the full amount owed to Dr. Cheney.

I understand and agree that I am responsible for the estimated amount not paid by the insurance company.

I understand that after the insurance company pays Dr. Cheney there could still be a balance remaining, for which I am responsible.

I understand and agree that if upon payment by the insurance company, there is a remaining balance; I am responsible for the amount in full at that time. If the balance remains for more than ninety days I am aware a finance charge will be applied to the balance for which I am responsible.

I authorize insurance payments be made to Amesbury Dental Associates.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Responsible Party Office Manager

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date

***Amesbury Dental Associates***

41 Sparhawk Street

Amesbury, Massachusetts 01913

978-388-3505

Office Policy Regarding Broken Appointments

We realize that in today’s society, schedules have become very hectic due to employment, children’s activities, etc., resulting in an increased demand of one’s time. A scheduled dental appointment can be forgotten due to unforeseen circumstances.

We make every effort to keep all patients informed of upcoming appointment dates and times. A reminder card is sent to patients for their recall (cleaning & exams) and a courtesy confirmation phone call is made the day prior to all appointments. When a patient fails an appointment or calls at the time of a scheduled appointment to cancel, that time is lost and it is impossible to fill that slot. Because our time is just as valuable as yours is, any cancellations must be made at least 24 hours in advance or a minimum charge of $ 50.00 will be assessed. Additional charges may be applied based on the length of the appointment.

When appointments are consistently failed or cancelled it compromises our ability to help maintain your dental health and patient doctor relationship. Should this occur with frequency you may be dismissed as a patient.

In return for your consideration, we will continue to offer you the utmost in professional dental care, as well as schedule further appointments for you within a timely manner.

Thank you

Henry G. Cheney, Jr., D.M.D.

Brad Fulkerson, D.M.D.



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