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PATIENT HEALTH QUESTIONNAIRE

Patient Name: ________________________________ Today's Date: ______________________

Preferred Name: ________________________________ Date of Birth: ______________________

Address: ____

City: ______________________________ State: ______________ Zip: ____________________

Phone (C): ____________________ (H): ____________________ (W): ____________________

Email: ____

SSN: ______________________________ Employer: ______________________________

Is the Patient the Responsible Party for Payment? ☐ Yes ☐ No If no, please fill out the information below.

Responsible Party Name: ____

Address: ____

City: ______________________________ State: ______________ Zip: ____________________

Phone (C): ____________________ (H): ____________________ (W): ____________________

Email: ____

SSN: ______________________________ Employer: ______________________________

Reason for your Visit:

☐ Exam/Cleaning ☐ Emergency ☐ Consultation ☐ Invisalign ☐ Other

If other, please explain: ____

Do you require antibiotic premedication prior to dental treatment? ☐ Yes ☐ No

Are you currently experiencing any dental pain? ☐ Yes ☐ No

If so, where and for how long? ____

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Please check the corresponding box if you are currently experiencing any of these problems:

- ☐ Red, Swollen or Bleeding Gums
- ☐ Sensitive Teeth or Gums
- ☐ Lost/Broken Fillings or Teeth
- ☐ Loose/Shifting Teeth
- ☐ Food Caught between Teeth
- ☐ Swelling/Lumps in Mouth
- ☐ Blisters or Sores in/around the Mouth
- ☐ Burning Tongue/Lips
- ☐ Stained Teeth
- ☐ Bad Breath

My teeth are sensitive to:

☐ Hot ☐ Cold ☐ Sweets ☐ Biting/Chewing

Approximate date of last dental exam/x-rays: ____________________

How many times a day do you brush? ____________________

How many times a day do you floss? ____________________

Do you use an electric or manual toothbrush? ____________________

On a scale of 1 – 10, (10 being very healthy) how would you rate your general health? __________

Please mark all that apply to you:

- ☐ Locking Jaw
- ☐ Headaches/Migraines
- ☐ Difficult Swallowing
- ☐ Facial Pain
- ☐ Postural Problems
- ☐ Bell's Palsy
- ☐ Limited Jaw Opening
- ☐ Ringing in the Ears
- ☐ Clenching/Grinding
- ☐ Neck/Shoulder Pain
- ☐ Tingling Fingertips
- ☐ Trigeminal Neuralgia
- ☐ Jaw Joint Pain, Clicking or Popping
- ☐ Ear Congestion
- ☐ Difficulty Chewing
- ☐ Dizziness
- ☐ Nervousness/Insomnia

____________________________________ ____________________

Signature of Patient, Parent, or Guardian Print Name Date

Relationship to Patient: ____________________

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MEDICAL HISTORY

Patient Name: ________________________________ Date of Birth: ________________________

Describe your general health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? ☐ Yes ☐ No

Physician's Name: ________________________________ Office Phone: ________________________

Are you required to pre-medicate (with antibiotics) for dental appointments? ☐ Yes ☐ No ☐ Not Sure

List all medications you are currently taking: ____

____

____

Are you taking any blood thinners (such as Coumadin, Warfarin, Plavix, Aspirin, Vitamin E, or fish oil) ☐ Yes ☐ No

Are you allergic to any of the following?

☐ Aspirin ☐ Codeine ☐ Erythromycin ☐ Dental Anesthetic ☐ Latex ☐ Penicillin ☐ Percodan

☐ Other, please list: ____

Have you ever had any of the following?

☐ AIDS/HIV positive	☐ Diabetes	☐ Hepatitis A	☐ Radiation Treatments
☐ Alzheimer's Disease	☐ Drug Addiction	☐ Hepatitis B	☐ Recent weight loss
☐ Anaphylaxis	☐ Easily Winded	☐ Hepatitis C	☐ Renal Disease
☐ Anemia	☐ Emphysema/COPD	☐ Herpes	☐ Rheumatic Fever
☐ Angina	☐ Epilepsy or Seizures	☐ High Blood Pressure	☐ Shingles
☐ Arthritis/Gout	☐ Excessive Bleeding	☐ High Cholesterol	☐ Sickle Cell Disease
☐ Artificial Heart Valve	☐ Excessive Thirst	☐ Hives/Rash	☐ Sinus Issues
☐ Artificial Joint	☐ Fainting/Dizziness	☐ Hypoglycemia	☐ Snoring
☐ Blood Disease/ Disorder	☐ Frequent Cough	☐ Irregular Heartbeat	☐ Stomach Issues
☐ Blood Transfusion	☐ Frequent Diarrhea	☐ Kidney Problems	☐ Stroke
☐ Breathing Problems	☐ Frequent Headaches	☐ Leukemia	☐ Swelling of limbs
☐ Bruise Easily	☐ Glaucoma	☐ Liver Disease	☐ Thyroid Disease
☐ Cancer	☐ Heart attack/failure	☐ Low blood pressure	☐ Tuberculosis
☐ Chemotherapy	☐ Heart murmur	☐ Lung Disease	☐ Tumors or Growths
☐ Chest pain	☐ Heart Pacemaker	☐ Mitral Valve Prolapse	☐ Ulcers
☐ Cold sores /fever blisters	☐ Heart Disease	☐ Osteoporosis	☐
☐ Congenital Heart Disorder	☐ Yellow Jaundice	☐ Jaw Pain	☐
☐ cortisone medicine	☐ Hemophilia	☐ Psychic Care	☐

Do you have any disease, condition, or problem not listed above that you think we should know about?

____

Do you use tobacco? ☐ Yes ☐ No If yes, how much? ______________________________________

Women: Are you pregnant? ☐ Yes ☐ No If yes, how far along? ________________ Are you nursing? ☐ Yes ☐ No

To the best of my knowledge, all the above information is true and correct. If there are any changes, I will advise the doctor.

Signature of Patient or Responsible Party: ____

Printed Name ________________________________ Date: ________________________

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HANDLE ME WITH CARE

Name: ____ Date: ____________________________

We want you to be comfortable during your visit, so please put a checkmark next to the statement that describes how you feel about going to the dentist and your overall care. Check as many as you like.

- ☐ I gag easily.
- ☐ I feel out of control while lying in the dental chair.
- ☐ I have a problem with being tipped back in the dental chair.
- ☐ I am very anxious about injections.
- ☐ I hate the noise of dental instruments.
- ☐ I have not been seen by a dentist for a long time and I am worried about what you will tell me about my dental hygiene.
- ☐ I am embarrassed about the way my teeth look.
- ☐ I have had a bad experience and I have a lot of fear which has kept me from getting the dental care I need.
- ☐ I am very apprehensive about the possibility of experiencing pain.
- ☐ I have difficulty listening and remembering when I am in the dental chair.
- ☐ I want to be able to ask as many questions as necessary so that I understand why and what treatment is being recommended for me.
- ☐ I would like to see pictures and videos that will help me understand my dental problems and possible solutions.
- ☐ There are other concerns I would like to talk about: ________________________________

  ____

  ____

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COMMUNICATION CONSENT FORM

Patient Name: ________________________________

In order to comply with HIPAA (Health Insurance Portability and Accountability Act of 1996) regulations, we ask that our patients review and sign this Communication Consent Form.

Meyer Heim Dental will not release confidential and/or other Protected Health Information (PHI) in any written or recorded manner unless authorized by you to do so. Additionally, information will not be left with an unauthorized person who may answer the telephone or call in on your behalf.

I, ____________________________, authorize Meyer Heim Dental to contact me and/or my named authorized person(s) to convey **Protected Health Information (PHI)** by the following methods and assume responsibility to notify Meyer Heim Dental when this information changes:

Email on record: ☐
Cell Phone on record: ☐
Home Phone on record: ☐
Home Address on record: ☐
Any of the Above: ☐
Other: ______________________________

Meyer Heim Dental may need to contact you to discuss payment for services rendered.

I, ____________________________, authorize Meyer Heim Dental to contact me and/or my named authorized person(s) to convey **billing information** by the following methods and the home address on record. I assume responsibility to notify Meyer Heim Dental when this information changes:

Email on record: ☐
Cell Phone on record: ☐
Home Phone on record: ☐
Any of the Above: ☐
Other: ______________________________

Meyer Heim Dental uses text, email and phone reminders to confirm appointments.

I, ____________________________, authorize Meyer Heim Dental to contact me and/or my named authorized person(s) to convey **appointment information** by the following methods and assume responsibility to notify Meyer Heim Dental when this information changes:

Email on record: ☐
Cell Phone on record: ☐
Home Phone on record: ☐
Any of the Above: ☐
Other: ______________________________

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Patient Name: ______________________________

Who may we contact in case of an emergency?

Name: ____ Relationship: _____________________

Phone Number: ____

Please tell us who is authorized to receive protected information about your care:

Emergency Contact Listed above: ☐ Yes ☐ No

Name: ____ Relationship: _____________________

Name: ____ Relationship: _____________________

____ ______________________________
Patient Signature Date

____ ______________________________
Parent/Guardian Signature Date

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MEYER HEIM DENTAL OFFICE POLICY

Patient Name: ________________________________

It is the goal of this office to provide you with the finest quality dental care possible. We believe that a clear definition of our financial and insurance policies will allow the patient, doctor and staff to concentrate on the most important issue—regaining and maintaining your dental health.

Payment for Services:

We require payment in full for all services rendered at the time of visit, unless other arrangements have been made in writing with our business manager. If an account is not paid within 90 days of the date of service and no financial arrangements have been agreed upon, you will be responsible for legal fees, collection agency fees, interest charge and any other expenses occurred in collecting your account.

Missed Appointments:

If you need to reschedule or cancel your appointment, we require 2 business days' advance notice to ensure we are able to best meet the needs of our patients that want in sooner. If you provide less than 2 business days' advance notice, you will be charged a $50.00 per hour missed appointment fee.

Dental Insurance:

As a courtesy to you, we will file your dental insurance claims for you. By signing this office policy, you are assigning all insurance benefits to us. Any deductibles and estimated co-payments must be paid on the day of service. If you prefer to submit your own dental claims, payment in full will be required on the day of service and you shall be provided with a copy of the statement.

Insurance Payments Only an Estimate:

Please understand that we are only able to estimate your insurance company's payment based on the information your insurance company provides us. Your dental insurance policy is a contract between you, your employer (if it is a group dental plan) and the insurance company. The dentist is not a party to the dental insurance contract. We do not guarantee that your insurance company will reimburse for services at the usual and customary fees nor does your insurance company guarantee the accuracy of benefits quoted to us by phone, fax, or online.

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Balance Due:

Not all dental services are covered benefits in all dental (or medical) insurance contracts. The filing of insurance claims is a courtesy that we extend to our patients; however, all charges are your responsibility from the day services are rendered regardless of insurance coverage. Any balance due after an insurance payment is received is your financial responsibility and a bill will be sent to you within 30 days after receiving insurance payment. Any payment received in excess of your balance will be credited to your account. We will refund of any credit balance upon your request using the original method of payment, with the exception of cash payments which will be refunded via check. If you prefer you may also use this credit toward any future services with us instead.

Refund Policy:

There is a significant amount of time, professional resources and costs associated with providing a patient with a customized treatment plan. Additionally, there are hard costs that are incurred for aligners, crowns, bridges, prosthetics, devices and oral appliances which are custom designed and manufactured for each patient and may be integral to the overall treatment provided. Because of this, WCD does not issue refunds on products or services. We realize that circumstances may arise from time to time that require special consideration, therefore WCD reserves the right to review any case on an individual basis and at our sole discretion.

By my signature below I acknowledge I have read and consent to the above policies, conditions of treatment and payment:

____ ________________________________
Signature of Guarantor of Payment/Responsible Party Date

Patient Name: ______________________________ Relationship to Patient:________________

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CONSENT FOR SERVICES

We invite you to discuss with us any questions regarding our services. The best dental health services are based on a friendly, mutual understanding between provider and patient.

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize Dr. Jay Heim or Dr. Sarah Meyer to use and disclose my protected health information to carry out the following:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third-party payers (i.e. insurance companies) or other financial institutions (i.e. credit card companies, financing companies);
- The day-to-day healthcare operations of Dr. Jay Heim or Dr. Sarah Meyer.

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that Dr. Jay Heim or Dr. Sarah Meyer reserves the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that Dr. Jay Heim or Dr. Sarah Meyer is not required to agree to these requested restrictions. However, if Dr. Jay Heim or Dr. Sarah Meyer does agree, then Dr. Jay Heim or Dr. Sarah Meyer is bound to comply with this restriction.

I understand that I may revoke this consent in writing at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

I authorize Dr. Jay Heim or Dr. Sarah Meyer to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

____   ____________________________
Signature of Patient, Parent, or Guardian   Date

Patient Name: _________________________   Relationship to Patient: __________________

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