Health History

Patient Name: _____ Date of Birth: _____

Medical Physician's Name: _____ Phone: _____

Yes No 1. Are you having dental pain?
Yes No 2. Are you in good health?
Yes No 3. Have you recently been under a physician's care?
Yes No 4. Do you take medications? If yes, please list with dosage: _____
_____
_____
Yes No 5. Have you had an adverse reaction to penicillin, codeine, local anesthetic or any other drugs? If so, please specify:
_____
Yes No 6. Do you have any sensory impairment including vision or hearing?
Yes No 7. Are you pregnant?
Yes No 8. Do you have a heart condition?
Yes No 9. Have you had joint replacements? (i.e. hip, knee)
Yes No 10. Have you ever had a heart valve replacement?

Yes No 11. Have you ever had? (Circle for yes)

Anemia	High / Low Blood Pressure	Sinus Infections
Arthritis	Kidney Disease	Stomach Problems
Asthma	Liver Disease	Stroke
Blood Disorders	Diabetes: list last A1C#___	Venereal Disease
Cancer	Respiratory Disorders	

Yes No 12 Autoimmune System Disorders, specify_____
Yes No 13. Have you ever taken any bone building medications? (Examples: Fosamax, Boniva)
Yes No 14. Do you use tobacco products or e-cigarettes? How often?_____
Yes No 15. Do you drink soda pop or energy drinks? If so, how many do you consume daily?_____
Yes No 16. Have you ever been diagnosed with Hepatitis, AIDS or any other infectious disease? If so, please specify:_____
Yes No 17. Do you have blood, bruising or bleeding problems?
Yes No 18. Are you subject to fainting?
Yes No 19. Do you have any other health or medical conditions that you are aware of? If so, please specify: _____

If this is your first visit in our office:
Have you ever had any reaction to dental treatment? If so, please specify_____
Who was your last dentist and when did you visit them last? _____
Were X-rays taken at that time? _____
Reason for today's visit: _____
Please add anything you feel is important. _____

HEALTH QUESTIONNAIRE ACKNOWLEDGEMENT AND CONSENT TO PROCEED: I certify that the answers to the health questions are accurate and correct the best of my knowledge. Since a change of medical condition or medications can affect dental treatment, I understand the importance and agree to notify the dentist of any changes in any subsequent appointment.
I authorize Booth Dental Doctors and/or such associates or assistants as she/he may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for whom I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to: bruising, hematoma, cardiac stimulation, and temporary or rarely, permanent numbness and muscle soreness. I understand that it is possible for needles to break during the administration of local anesthetic and that surgical recovery of the needle may be necessary.
I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventative and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the forgoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

Signature:_____ Date:_____
(Patient, legal guardian or authorized agent of patient)

Booth Dental

1245 Capitol St., Suite 101-S. Ogden, Utah 84401

PATIENT INFORMATION SHEET

In order to help us render the proper dental services to you, would you please be kind enough to answer the following questions on both sides of this form. Thank you for your cooperation.

PERSONAL

Patient's Name _____ Date _____

Date of Birth _____ Age _____ SS# _____ Martial Status S/M/D/W

Person Responsible for Account _____
(Complete Name)

_____
(Relationship) (Social Security Number) (Date of Birth)

Address _____ Phone _____

City, State & Zip _____ Cell Phone _____

Email Address _____

Present Employer _____ Occupation _____

Business Address _____ Phone _____

Spouse's Name _____ Spouse's Employer _____

Emergency Contact Person _____ Relationship _____

Address _____Phone _____

Whom may we thank for referring you? _____

INSURANCE INFORMATION

Name of Primary Dental Insurance Plan _____

Name of Insured _____ Date of Birth _____

Group # _____ ID# _____

Name of Secondary Dental Insurance Plan _____

Name of Insured _____ Date of Birth _____

Group # _____ ID# _____

AGREEMENT FOR EXTENSION OF CREDIT

In accordance with the Federal Truth-In-Lending Act which requires all doctors to give their patients information in connection with extension of credit, please be advised of the following policies which apply in this office.
The responsible party agrees to:

1. Pay the doctor at the time treatment or service is received or by previous arrangement.
2. That if payments are extended beyond 90 days from the date of first filling to pay 1.5% per month on the unpaid balance (annual rate of 18%) with a minimum charge of .50 per month.
3. Pay the doctor the usual fee of $75 for broken appointments.

I/We agree to pay cost and/or reasonable attorney's fee, and a forty percent (40%) collection fee, if any delinquent balance is placed with an agency or attorney for collection or suit.

_____ _____
Date Signature: Responsible Person

See Reverse Side