Health History Form

American Dental Association
www.ada.org

E-mail: Today's Date:

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: Last First Middle
Home Phone: *Include area code* ( )
Business/Cell Phone: *Include area code* ( )

Address: Mailing address
City: State: Zip:

Occupation: Height: Weight: Date of birth: Sex: M F

SS# or Patient ID: Emergency Contact: Relationship: Home Phone: ( ) Cell Phone: ( ) *Include area codes*

If you are completing this form for another person, what is your relationship to that person?

Your Name Relationship

Do you have any of the following diseases or problems: *(Check DK if you Don't Know the answer to the question)*	**Yes**	**No**	**DK**
Active Tuberculosis	☐	☐	☐
Persistent cough greater than a 3 week duration	☐	☐	☐
Cough that produces blood	☐	☐	☐
Been exposed to anyone with tuberculosis	☐	☐	☐

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Dental Information *For the following questions, please mark (X) your responses to the following questions.*

	Yes	**No**	**DK**
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Does food or floss catch between your teeth?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐
Do you drink bottled or filtered water?	☐	☐	☐
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY			
Are you currently experiencing dental pain or discomfort?	☐	☐	☐

	Yes	**No**	**DK**
Do you have earaches or neck pains?	☐	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Do you brux or grind your teeth?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Do you participate in active recreational activities?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐

Date of your last dental exam:
What was done at that time?

Date of last dental x-rays:

What is the reason for your dental visit today?

How do you feel about your smile?

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

	Yes	**No**	**DK**
Are you now under the care of a physician?	☐	☐	☐

Physician Name: Phone: *Include area code* ( )

Address/City/State/Zip:

	Yes	**No**	**DK**
Are you in good health?	☐	☐	☐
Has there been any change in your general health within the past year?	☐	☐	☐

If yes, what condition is being treated?

Date of last physical exam:

	Yes	**No**	**DK**
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐	☐

If yes, what was the illness or problem?

	Yes	**No**	**DK**
Are you taking or have you recently taken any prescription or over the counter medicine(s)?	☐	☐	☐

If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements:

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Form S500

Medical Information

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

(Check DK if you Don't Know the answer to the question)

Question	Yes	No	DK
Do you wear contact lenses?	☐	☐	☐
Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	☐	☐	☐
Date: ____________ If yes, have you had any complications?_____________			
Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease?	☐	☐	☐
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?	☐	☐	☐
Date Treatment began: ______________________________________			
Do you use controlled substances (drugs)?	☐	☐	☐
Do you use tobacco (smoking, snuff, chew, bidis)?	☐	☐	☐
If so, how interested are you in stopping? (Circle one) VERY / SOMEWHAT / NOT INTERESTED			
Do you drink alcoholic beverages?	☐	☐	☐
If yes, how much alcohol did you drink in the last 24 hours? ____________			
If yes, how much do you typically drink In a week? ____________________			

WOMEN ONLY Are you:

Question	Yes	No	DK
Pregnant?	☐	☐	☐
Number of weeks: ___________			
Taking birth control pills or hormonal replacement?	☐	☐	☐
Nursing?	☐	☐	☐

Allergies - Are you allergic to or have you had a reaction to:
To all **yes** responses, specify type of reaction.

Allergy	Yes	No	DK
Local anesthetics________________	☐	☐	☐
Aspirin________________	☐	☐	☐
Penicillin or other antibiotics________________	☐	☐	☐
Barbiturates, sedatives, or sleeping pills ________________	☐	☐	☐
Sulfa drugs ________________	☐	☐	☐
Codeine or other narcotics ________________	☐	☐	☐
Metals________________	☐	☐	☐
Latex (rubber) ________________	☐	☐	☐
Iodine ________________	☐	☐	☐
Hay fever/seasonal ________________	☐	☐	☐
Animals________________	☐	☐	☐
Food ________________	☐	☐	☐
Other ________________	☐	☐	☐

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

Condition	Yes	No	DK
Artificial (prosthetic) heart valve	☐	☐	☐
Previous infective endocarditis	☐	☐	☐
Damaged valves in transplanted heart	☐	☐	☐
Congenital heart disease (CHD)			
Unrepaired, cyanotic CHD	☐	☐	☐
Repaired (completely) in last 6 months	☐	☐	☐
Repaired CHD with residual defects	☐	☐	☐

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

Condition	Yes	No	DK
Cardiovascular disease.	☐	☐	☐
Angina	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Congestive heart failure	☐	☐	☐
Damaged heart valves	☐	☐	☐
Heart attack	☐	☐	☐
Heart murmur	☐	☐	☐
Low blood pressure	☐	☐	☐
High blood pressure	☐	☐	☐
Other congenital heart defects	☐	☐	☐
Mitral valve prolapse	☐	☐	☐
Pacemaker	☐	☐	☐
Rheumatic fever	☐	☐	☐
Rheumatic heart disease	☐	☐	☐
Abnormal bleeding	☐	☐	☐
Anemia	☐	☐	☐
Blood transfusion	☐	☐	☐
If yes, date:__________________			
Hemophilia	☐	☐	☐
AIDS or HIV infection	☐	☐	☐
Arthritis	☐	☐	☐
Autoimmune disease	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Systemic lupus erythematosus.	☐	☐	☐
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐
Tuberculosis	☐	☐	☐
Cancer/Chemotherapy/ Radiation Treatment	☐	☐	☐
Chest pain upon exertion	☐	☐	☐
Chronic pain	☐	☐	☐
Diabetes Type I or II	☐	☐	☐
Eating disorder	☐	☐	☐
Malnutrition	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
G.E. Reflux/persistent heartburn	☐	☐	☐
Ulcers	☐	☐	☐
Thyroid problems	☐	☐	☐
Stroke	☐	☐	☐
Glaucoma	☐	☐	☐
Hepatitis, jaundice or liver disease	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Neurological disorders	☐	☐	☐
If yes, specify:__________________			
Sleep disorder	☐	☐	☐
Mental health disorders	☐	☐	☐
Specify:__________________			
Recurrent Infections	☐	☐	☐
Type of infection:__________________			
Kidney problems	☐	☐	☐
Night sweats	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistent swollen glands in neck	☐	☐	☐
Severe headaches/ migraines	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
Excessive urination	☐	☐	☐

Question	Yes	No	DK
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	☐	☐	☐

Name of physician or dentist making recommendation: Phone:

Question	Yes	No	DK
Do you have any disease, condition, or problem not listed above that you think I should know about?	☐	☐	☐

Please explain:

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about 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 action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: Date:

FOR COMPLETION BY DENTIST

Comments:____

____

____

____

DR. HELEN TRAN

PATIENT REGISTRATION
INFORMACION SOBRE EL PACIENTE

Name____Birth Date________________________S M D W C
Last, ApellidoFirst, Nombre Middle, Segundo Nombre (Nickname) *Fecha de Nacimiento* *Estado Civil*

Adress_______________________________________City____________________State________Zip__________
Direccion *Ciudad* *Estado* *Zona Postal*

Home Phone______________________Cell Phone_____________________Work Phone_____________________
Telefono *Celular* *Trabajo*

Employer____Occupation__________________________________
Lugar donde Trabaja *Occupacion*

Insurance Information

Primary Insurance Carrier______________________________________Insurance Phone #__________________
Aseguranza Principal *Telefono*

Member ID#____Group #____________________________________
Politica/No. de Identificacion *No. de Grupo*

Name of Policy Holder_____________________________________Sex: M / F Date of Birth________________
Nombre del Asegurado *Fecha de nacimiento*

Policy Holders Address____Phone#________________________
Direccion del Asegurado *Telefono*

Policy Holders Employer____Work #___________________________
Nombre del Empleador *Telefono del Trabajo*

Relationship of Patient to Policy Holder: Self Husband Wife Child Other
Relacion con el Paciente

Secondary Insurance Carrier_____________________________________Insurance Phone#_________________
Compania de Seguros *Telefono*

Member ID#____Group#__________________________________
Politica/No. de Identificacion *No. de Grupo*

Name of Policy Holder_____________________________________Sex: M / F Date of Birth________________
Nombre del Asegurado *Fecha de nacimiento*

Policy Holder Address____Phone#________________________
Direccion de Asegurado *Telefono*

Policy Holders Employer____Work#_________________________
Nombre del Empleador *Telefono del Trabajo*

I authorize release of any information relating to this claim. I understand that I am responsible for all costs of dental treatment. ***Yo authorizo que qualquier informacion respecto a esta reclamacion sea ofrecida. Entiendo que soy resoponsable por el costo del tratamiento dental.*** ____________________________ ____________________ **Signed (Patient, or Parent if Minor** **Date** ***Firma (Paciente O Padres)*** ***Fecha***	I hereby authorize insurance payment directly to Dr. Helen Tran. ***Yo authorizo el pago del seguro directamente a la Dr. Helen Tran*** ______________________________ ____________________ **Signed (Patient, or Parent if Minor** **Date** ***Firma (Paciente O Padres)*** ***Fecha***

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Dr. Helen B. Tran
5415 S. Cooper St., Suite 127
Arlington, TX 76017
817-466-1131

I understand that, under the Insurance Portability & Accounting Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct plans direct my treatment and follow-up among multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment form third party payer.
- Conduct normal healthcare operations such as quality assessments and doctor certifications.

____
Patient's name

____
Signature of Patient or Personal Representative

____
Description of Personal Representative's Authority

____
Date

Dr. Helen B. Tran PC
5415 S. Cooper St, #127
Arlington, TX 76017
817-466-1131

Date: _____________

Agreement to Pay

Patient name:____

I am the responsible party for the above patient, I agree to pay for any dental treatment of the above patient if insurance does not cover for such procedures, or the patient has no insurance.

Also if my account is sent to a collection agency, I agree to pay for the collection fee.

Name:____

Signature: ______________________________________

Dr. Helen B. Tran PC
5415 S. Cooper St., suite 127
Arlington, Texas 76017
817-466-1131

Authorization to share information

Date: ________________________________

I ____________________________________ , authorize Dr. Helen Tran and staff to

share my clinical and financial account information with the following person(s) :

1. ____
2. ____
3. ____
4. ____

Signature: _____________________________________

PATIENT REGISTRATION
INFORMACION SOBRE EL PACIENTE

Patient Name: ____

Nombre del Paciente: ____

If Child, Parent's Name: ____

En caso de ser menor, nombre del padre: ______________________________________

1.How did you hear about us? ____

Como oiste acerca de nosostros? ____

2.When was your last Dental Visit? ____

Cuando fue la ultima vez que haz ido al dentista? ________________________________

3.What was done on your last Visit? ____

Que se le realizo? ____

4.When was your last Full Mouth x-rays (small x-rays) taken ? _____________________

Cuando le fue realizada su ultima serie de radiografias completa? _________________

5.When was your last Panorex (big x-ray) taken? _________________________________

Cuando le fue realizada su radiografia panoramica? ______________________________

6.When was your last Cleaning? _______________ Did they take x-rays at that appointment?____

*Cuando fue su ultima limpieza dental?*__________ *Se le realizo alguna radiografia en esa cita?* ____

7.If you have insurance, since when have you had this insurance? Month_____Year____

*Si tiene usted seguranza, desde cuando la tienes? Mes*_______*Ano*___________________

Dr. Helen B. Tran DMD
5415 South Cooper St., #127
Arlington, Texas 76017

AUTHORIZATION TO TEXT AND EMAIL

Due to the changing world of healthcare and technology, Dr. Helen Tran's office now has the ability to provide our patients with certain types of information via e-mail and/or text messaging. If you wish to have the opportunity to receive information of this type, please complete the form below.

Dr. Helen Tran believes strongly in protecting the privacy of our patients. When you provide this information to us, it is only used as a way to communicate with you. In order to protect your privacy, no confidential or personal information will be sent from the Dr. Helen Tran's office via email or text messaging. Dr. Helen Tran's office does not share the names, e-mail addresses, and/or telephone numbers of patients with any other company, or with any other patient.

Please print all information neatly and legibly.

Name ______________________________________

E-mail address________________________________

Cell phone ___________________________________

- ◦ Yes, please sign me up to receive e-mail and text messaging confirmations.
- ◦ I do not wish to be contacted via e-mail. (Text messaging only)
- ◦ I do not wish to be contacted via text messaging. (E-mail only)
- ◦ I do not wish to be contacted by either text messaging or e-mail.

Signature : ________________________________ Date: _______________

CONSENT FOR TREATMENT

1. I hereby authorize doctor designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by Dr. Helen Tran to make a thorough diagnosis of (name of patient)____’s dental needs.

2. Upon such diagnosis, I authorize Dr. Helen Tran to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to use the anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

4. Lastly, I agree to be responsible for payment of all services rendered on my behalf of my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a late charge will be added to my account.

Patient____ Date___________________________

Parent or Responsible Party____

Relationship to Patient____

AUTHORIZATION DE TRATAMIENTO

1. Authorizo al doctor o al personal designado a tomar rayos-x, estudiar modelos, fotografias, y cualquier otra ayuda de dianostico que el Dr. Helen Tran considere apropiada para llevar a cabo un profundo diagnositco de las necesidades dentales de (nombre del paciente)____.

2. Basado en dicho diagnostico, authorize al Dr. Helen Tran a llevar a cabo todo tratamiento recomendado y que hayamos acordado mutuamente, y a emplear dicha asistencia como se requiera proveer el cuidado apropiado.

3. Estoy de acuerdo con el uso de anestescios, sedantes, y otros medicamentos que sean necesarios. Entiendo completamente que el uso de agents anestesicos conlleva ciertos riesgos. Entiendo quepuedo obtener una lista complete de cualquier complicacion possible.

4. Po ultimo, estoy de acuerdo en ser responsible por los pagos de los servicios que reciba yo o mis dependientes. Entiendo que los pagos se hacen al memento del servicio a menos que no se hagan otros arreglos. En el evento en que los pagos no se reciban en la fechas acordadas, entiendo que un cargo retraso sera anadido a m cuenta.

Paciente____ Fecha__________________________

Padres o Guardianes____

Relacion con el paciente____