JOHN HIGHSMITH, DDS
Cosmetic, General, Implant & Laser Dentistry
www.DrHighsmith.com

WELCOME TO OUR PRACTICE!

Patient's Full Name: ______________________________ Date: ______________

Mailing Address: ____

City: ________________________ State: ____________ Zip Code: ________

Home Phone: __________ Cell Phone: ___________ Work Phone: ______________

Email: __________________________ Birth Date: ______ SS#: ______________

Employer: ________________________ Occupation: ______________________

Referred by: ____

Spouse's Name: ____________________ Birth Date: ________ SS#: ___________

Spouse's Employer: __________________ Occupation: ____________________

Spouse's Work Phone: _______________ Spouse's Cell Phone: _________________

PERSON RESPONSIBLE FOR BILL IF NOT THE PATIENT

Name: ________________________ Relationship to Patient: _________________

Address: ____

City: _____________________ State: ____________ Zip Code: ___________

Birth Date: _________ SS#: ____________

Home Phone: ______________ Cell Phone: _____________ Work Phone: _________

Employer: _________________________ Occupation: ____________________

ALTERNATE CONTACT INFORMATION (other than spouse, could be a friend, neighbor, etc.)

Name: ____________________________ Relationship to Patient: _____________

Home Phone: ____________ Cell Phone: _____________ Work Phone: ____________

Patient's Name: ______________________________ **Birthdate:** ____________________

MEDICAL AND DENTAL HISTORY

What is the main reason for your visit? ____

____

Who is your Medical doctor? ____

Who was your previous dentist? ____

Why did you leave your previous dentist? ____

When were your last dental X-rays taken? ________________

Do you experience anxiety or fear regarding dental treatment? No ___ Yes ___ If yes, explain ______________

____

Are you allergic to or have you had a reaction to any medications or substances? No ___ Yes ___ If yes, please check.

Aspirin ___ Penicillin ___ Codeine ___ Iodine ___ Metal ___ Latex ___ Other______________________

Please list any medications you are currently taking. (Including over the counter medications and vitamins) ________

____

____

Are you or have you been treated for osteoporosis? No ___ Yes ___ If yes, please check and indicate how long.

Medications ______________________________ Injections ______________________________

Have you been hospitalized in the past 2 years? No ___ Yes___ If yes, explain ______________________

____

For Women: Are you Pregnant? No ___ Yes ___ Are you currently taking birth control pills? No ___ Yes ___

Do you use tobacco in any form? No ___ Yes ___ If yes, what type and how often? ____________________

Do you have or have you ever had any of the following? Please check all that apply:

___ Heart Disease: Type______
___ Atrial Fibrillation
___ Heart Attack: Date _______
___ Angina Pectoris
___ Mitral Valve Prolapse
___ Artificial Heart Valve
___ Heart Pacemaker
___ Heart Surgery: Date ______
___ High Blood Pressure
___ Artificial Joint: Date ______
___ Fainting
___ Stroke: Date _____
___ Kidney Problems
___ Thyroid Disease/Removal
___ Diabetes: 1___ 2 ___
___ Psychiatric Treatment

___ Epilepsy/Seizures
___ Emphysema/COPD
___ Cancer
___ Radiation/Chemotherapy
___ Sleep Apnea ___CPAP
___ GERD (Acid Reflux)
___ Parkinson's disease
___ Arthritis
___ Tuberculosis
___ Anorexia/Bulimia
___ STD
___ Cold Sores
___ HIV/AIDS
___ Hepatitis: A___B___C___
___ Drug/Alcohol Addiction

___ TMJ:Jaw Joint ___ Pain ___ Popping
___ Tinnitis (Ringing of Ears)
___ Dizziness
___ Grinding/Clenching Teeth
___ Sensitive Teeth
___ Neck Pain
___ Facial Pain
___ Ear Congestion/ Stuffiness
___ Headaches:
How often? ________________
___ Migraine Headaches:
How often? ________________
___ Sinus Problems
___ Asthma
___ Fibromyalgia

Is there any other medical condition you feel Dr. Highsmith needs to be aware of? No ___ Yes ___ If yes, what? _____

____

____

Patient's Name: ______________________ **Birthdate:** ___________

How many headaches do you have per week? ___________

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the situations described below, in contrast to feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently try to work out how they would have affected you.

Use the following scale to choose the **most appropriate number** for each situation:

0 = would **never** doze
1 = **slight** chance of dozing
2 = **moderate** chance of dozing
3 = **high** chance of dozing

SITUATION	**CHANCE OF DOZING**
Sitting and reading	___________
Watching television	___________
Sitting inactive in a public place	___________
Being a passenger in a motor vehicle for an hour or more	___________
Lying down in the afternoon	___________
Sitting and talking to someone	___________
Sitting quietly after a lunch without alcohol	___________
In a car, while stopped for a few minutes in the traffic	___________
Total Score	___________

1 - 6	You are getting enough sleep
7 - 8	Your score is average
9 and up	**You need to seek advice of a sleep specialists without delay**

Patient's Name: ______________________________ **Birthdate:** ____________________

HEALTH INFORMATION

I affirm that my health history is accurate and complete to the best of my knowledge. I will not hold Dr. Highsmith or any member of his team responsible for problems arising from errors or omissions that I made in the completion of this form.

GENERAL CONSENT FOR TREATMENT

I agree and consent to a dental examination by Dr. Highsmith. I understand that additional diagnostic procedures and dental treatment may be recommended and will be discussed with me prior to being done. Also, I acknowledge that there are no guarantees, expressed or implied, as to the results of any procedures or dental treatments performed.

APPOINTMENT POLICY

We value your time so you can expect us to see you at the appointed time. In return, when you make an appointment with us please be on time since we have reserved our time just for you. Please make every effort not to change your scheduled appointment. If you must change an appointment, please provide us at least **2 working days advance notification** so that we may use our time to accommodate other patients. We reserve the right to charge for cancelled or broken appointments. Broken and missed appointments create scheduling problems for other patients and our practice. We value your time, please value ours.

FINANCIAL POLICY

Payment in full is due the day of treatment. If you have dental insurance we are happy to file it for you if you provide us with the proper information. We do not accept insurance as a form of payment. All insurance benefits will be made payable to you. We work with finance companies that offer short and long-term financing options. Balances in excess of 60 days are subject to a finance charge of 1.5% per month (18% annual).

HIPAA (HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT)

We are required by applicable state and federal law to maintain the privacy of your health information. A copy of our privacy practice is available upon request.

PHOTOGRAPHY RELEASE

I authorize Dr. Highsmith to take photographs of my teeth to help me better understand my current dental conditions and possible treatment options. I also authorize him to show these photographs (teeth only, not identifiable) to other patients to better explain their treatment options.

I have read and understand the above information regarding accuracy of my **Health History**, **General Consent for Treatment**, **Appointment Policy**, **Financial Policy**, **HIPPA – Privacy Practices**, and **Photography Release**.

Signature: ______________________________ **Date:** ____________________