

-Continued-

Personal Primary Care Physician: _____

Facility Name / Phone #: _____

PERSON TO BE CONTACTED IN CASE OF EMERGENCY (other than home #):

Name	City	Phone#
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DENTAL INFORMATION:

1. What is the purpose of your dental visit today?

2. Date of last dental visit ~ _____
3. Date of last x-rays taken ~ _____
4. Name of previous Dentist ~ _____
5. Do you like your smile? YES _____ NO _____
6. Would you like whiter teeth? YES _____ NO _____
7. Would you like straighter teeth? YES _____ NO _____
8. Do you or your spouse have trouble with snoring? YES _____ NO _____
9. What do you expect of us to help meet your dental goals?

How did you hear about us? We'd like to know!

Patient _____ Yellow Pages _____ Newspaper _____
Internet/Website _____ Sign outside of office _____ Other _____

SIGNATURE: X _____ DATE: _____

2022 UPDATED MEDICAL HX FORM

Patient Name:

Birth Date:

Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, c

Do you currently have mercury (silver fillings) that you would like removed? Yes No

Are you under a physician's care now? Yes No

If yes

Have you ever been hospitalized or had a major operation? Yes No

If yes

Have you ever had a serious head or neck injury? Yes No

If yes

Have you been prescribed medications in the past 6 months / are you taking any medications now? If so, Yes No

If yes

Do you take, or have you taken, Phen-Fen or Redux? Yes No

If yes

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No

If yes

Are you on a special diet? Yes No

If yes

Do you use tobacco? Yes No

Do you take any alternative medications (supplements/herbs/vitamins)? Yes No

If yes

Do you require a premed prior to dental procedures? Yes No

If yes

Women: Are you...

Pregnant?

Nursing/breastfeeding?

Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin

Penicillin

Codeine

Acrylic

Metal

Latex

Sulfa Drugs

Local Anesthetics

Peanuts

Other Allergies?

Yes No

If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive Yes No

Cortisone Medicine Yes No

Hemophilia Yes No

Radiation Treatments Yes No

Alzheimer's Disease Yes No

Diabetes Yes No

Hepatitis A Yes No

Recent Weight Loss Yes No

Anaphylaxis Yes No

Drug Addiction Yes No

Hepatitis B or C Yes No

Renal Dialysis Yes No

Anemia Yes No

Easily Winded Yes No

Herpes Yes No

Rheumatic Fever Yes No

Angina Yes No

Emphysema Yes No

High Blood Pressure Yes No

Rheumatism Yes No

Arthritis/Gout Yes No

Epilepsy or Seizures Yes No

High Cholesterol Yes No

Scarlet Fever Yes No

Artificial Heart Valve Yes No

Excessive Bleeding Yes No

Hives or Rash Yes No

Shingles Yes No

Artificial Joint Yes No

Excessive Thirst Yes No

Hypoglycemia Yes No

Sickle Cell Disease Yes No

Asthma Yes No

Fainting Spells/Dizziness Yes No

Irregular Heartbeat Yes No

Sinus Trouble Yes No

Blood Disease Yes No

Frequent Cough Yes No

Kidney Problems Yes No

Spina Bifida Yes No

Blood Transfusion Yes No

Frequent Diarrhea Yes No

Leukemia Yes No

Stomach/Intestinal Disease Yes No

Breathing Problems Yes No

Frequent Headaches Yes No

Liver Disease Yes No

Stroke Yes No

Bruise Easily Yes No

Genital Herpes Yes No

Low Blood Pressure Yes No

Swelling of Limbs Yes No

Cancer Yes No

Glaucoma Yes No

Lung Disease Yes No

Thyroid Disease Yes No

Chemotherapy Yes No

Hay Fever Yes No

Mitral Valve Prolapse Yes No

Tonsillitis Yes No

Chest Pains Yes No

Heart Attack/Failure Yes No

Osteoporosis Yes No

Tuberculosis Yes No

Cold Sores/Fever Blisters Yes No

Heart Murmur Yes No

Pain in Jaw Joints Yes No

Tumors or Growths Yes No

Congenital Heart Disorder Yes No

Heart Pacemaker Yes No

Parathyroid Disease Yes No

Ulcers Yes No

Convulsions Yes No

Heart Trouble/Disease Yes No

Psychiatric Care Yes No

Venereal Disease Yes No

Yellow Jaundice Yes No

Lyme Disease Yes No

Sleep Apnea Yes No

Have you ever had any serious illness not listed above? Yes No

If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date: _____

*Pleasant Avenue Dentistry
Dr. Ben Sitz & Dr. Elise Soulliere
406 Pleasant Avenue South
Park Rapids, MN 56470
Phone (218)237-7200*

CANCELLATION POLICY

We understand that sometimes appointments may need to be rescheduled. We request that you give our office at least a 24-hour notice that you will be unable to keep your scheduled appointment. We will at that time help to find a better time/date to accommodate you and then reschedule your appointment. If for any reason you cannot give a 24-hour notice, you will be charged a fee of \$50.00 or more, depending upon the amount of treatment that was scheduled for that particular appointment, and the reason for canceling. We reserve specific amounts of time in our schedule for our patients, ensuring them that they will get the proper treatment and care during that time. Our patients are very valuable to us, as is our time with them. We ask that you please be considerate to this request.

Signature X _____ Date _____

OUR OFFICE PAYMENT POLICY

Ensuring that our patients receive high quality care is the goal of our practice.

Payment is due at the time of treatment. (No exceptions unless prior approval has been made with our office staff). We accept cash, check and any major debit/credit cards. We also have a payment plan called CareCredit, which allows you to start treatment today and spread payments over time, with the possibility of interest-free time.

Please circle the form of payment you will use to settle your account today.

PAYMENT OPTIONS:

1. CASH
2. CHECK
3. MAJOR CREDIT CARD or DEBIT CARD
4. Pleasant Avenue Dentistry PRIVATE DENTAL PLAN (ask for details)
5. CARECREDIT

Applying for CareCredit only takes a few minutes and there is no fee to apply.
If CareCredit is declined, another form of payment listed above is required at the time of service.

Signature of Patient/Responsible Party

Date

Pleasant Avenue Dentistry
Dr. Ben Sitz & Dr. Elise Soulliere
406 Pleasant Avenue South
Park Rapids, MN 56470
Ph. (218) 237-7200
Fax (218) 237-7201

There are no exceptions for patients with dental or medical insurance.

Pleasant Avenue Dentistry
Dr. Ben Sitz & Dr. Elise Soulliere

Patient Consent / Acknowledgement Form

By signing below, you consent to the use and disclosure of your protected health information by Dr. Ben Sitz, Dr. Elise Soulliere, our staff, and our business associates for treatment, payment, and health care operations. For a more detailed description of uses and disclosure for these purposes, please review our Notice of Privacy Practices. You have the right to review our Notice prior to signing this consent. The terms of this Notice may change. If the terms do change, you may obtain a revised Notice by simply contacting this office at (218) 237-7200 and requesting a revised Notice. We will also post any revised notice in the office. You have the right to request that we restrict our uses or disclosures of your protected health information which we are otherwise permitted to make for treatment, payment and health care operations, although we are not required to these restrictions. However, if we agree to further restrictions, they are binding on us. Finally, you may refuse to consent to the use or disclosure of your protected health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Protected Health Information (PHI).

THIS FORM IS ALSO USED TO OBTAIN ACKNOWLEDGEMENT OF RECEIPT OF OUR NOTICE OF PRIVACY PRACTICES OR TO DOCUMENT OUR GOOD FAITH EFFORT TO OBTAIN THAT ACKNOWLEDGEMENT.

I HAVE REVIEWED, UNDERSTAND AND AGREE TO THE CONTENT OF THE NOTICE OF PRIVACY.

SIGNATURE(S) _____ DATE _____
*****A SIGNATURE IS NEEDED FOR EACH MEMBER OF THE FAMILY. CHILDREN UNDER THE AGE OF 18 MUST HAVE A PARENT/GUARDIAN SIGNATURE*****

FOR OFFICE USE ONLY

If patient does not sign, please specify why patient chose not to sign the consent/acknowledgement of the notice of privacy.

All forms are for educational use only and do not constitute legal advice.
All forms are subject to change in the Federal Law and applicable State Laws.
Seek legal advice before use.