STAHL DENTAL STUDIO

Dental & Health History

DENTAL HISTORY

WHAT WOULD YOU LIKE US TO DO TODAY? ______________________

ARE YOU IN DENTAL DISCOMFORT TODAY: ☐ Yes ☐ No

FORMER DENTIST ______________ FORMER DENTIST'S PHONE ______________

DATE OF LAST DENTAL CARE ______________ DATE OF LAST X-RAYS ______________

PLEASE CHECK IF YOU HAVE HAD ANY PROBLEMS WITH THE FOLLOWING:

☐Y ☐N Sensitivity to sweets
☐Y ☐N Sensitivity biting
☐Y ☐N Sensitivity to hot
☐Y ☐N Sensitivity to cold
☐Y ☐N Clicking or popping jaw
☐Y ☐N Periodontal treatment
☐Y ☐N Bad breath
☐Y ☐N Bleeding gums
☐Y ☐N Food collection between teeth
☐Y ☐N Grinding or clenching teeth
☐Y ☐N Loose teeth or broken fillings
☐Y ☐N Sores or growths in mouth

HOW OFTEN DO YOU BRUSH? ______________ FLOSS? ______________

HOW DO YOU FEEL ABOUT THE APPEARANCE OF YOUR TEETH? ______________

HAVE YOU EVER EXPERIENCE AN ADVERSE REACTION DURING OR IN CONJUNCTION WITH A MEDICAL OR DENTAL PROCEDURE? ☐ Yes ☐ No

PLEASE TELL US ANY OTHER INFORMATION ABOUT YOUR DENTAL HEALTH OR PREVIOUS DENTAL TREATMENT: ______________

MEDICAL HISTORY

NAME OF PERSONAL PHYSICIAN ______________ PHONE ______________ DATE OF LAST VISIT ______________

HAVE YOU HAD ANY SERIOUS ILLNESSES OR OPERATIONS? ☐ Yes ☐ No

IF YES, PLEASE DESCRIBE: ______________

ARE YOU CURRENTLY UNDER THE CARE OF A PHYSICIAN? ☐ Yes ☐ No IF YES: ______________

HAVE YOU EVER HAD A BLOOD TRANSFUSION? ☐ Yes ☐ No IF YES, APPROXIMATE DATE: ______________

HAVE YOU EVER TAKE FEN-PHEN/REDUX: ☐ Yes ☐ No

WOMEN, ARE YOU PREGNANT? ☐ Yes ☐ No NURSING? ☐ Yes ☐ No TAKING BIRTH CONTROL PILLS? ☐ Yes ☐ No

PLEASE LIST ANY ALLERGIES THE PATIENT HAS:

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Please turn over...

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PLEASE CHECK IF YOU HAVE ANY OF THE FOLLOWING:

- ☐ AIDS/HIV Positive
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial heart valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Atopic (allergy prone)
- ☐ Back problems
- ☐ Body disease
- ☐ Cancer
- ☐ Chemical dependency
- ☐ Chemotherapy
- ☐ Circulatory problems
- ☐ Cortisone treatments
- ☐ Cough, persistent
- ☐ Cough up blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Food Allergies
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart murmur
- ☐ Heart problems: __________ DESCRIBE
- ☐ Hemophilia/Abnormal bleeding
- ☐ Herpes
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ Jaw pain
- ☐ Kidney disease or Malfunction
- ☐ Liver disease
- ☐ Material allergies (latex, wool, metal, chemicals)
- ☐ Medication for bone replacement therapy or Osteoporosis (Actinol, Boniva, etc.)
- ☐ Mitral valve prolapse
- ☐ Nervous problems
- ☐ Pacemaker/Heart surgery
- ☐ Psychiatric care
- ☐ Rapid weight gain or loss
- ☐ Radiation treatment
- ☐ Respiratory disease
- ☐ Rheumatic/Scarlet fever
- ☐ Shingles
- ☐ Shortness of breath
- ☐ Skin rash
- ☐ Spina Bifida
- ☐ Stroke
- ☐ Sulfa allergy
- ☐ Surgical Implant
- ☐ Swelling of feet or ankles
- ☐ Thyroid disease or malfunction
- ☐ Tobacco habit
- ☐ Heart problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer/Colitis
- ☐ Venereal disease

PLEASE LIST ANY MEDICATIONS THAT PATIENT IS TAKING:

NAME OF MEDICATION	PURPOSE

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist. I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment benefits. I understand that I am financially responsible for all charges whether or not paid by the insurance.

DATE __________ SIGNATURE __________

Payment is due in full at time of treatment, unless prior arrangements have been approved.

Adjunctive Oral Cancer Screening Acceptance Form

Complete each time the examination is performed and place in the patient's file

Our practice continually strives to provide important enhancements in oral health care for our patients. We are concerned about oral cancer and look for it in all at risk patients.

One person dies every hour from oral cancer in the United States.

Late detection of oral cancer is the primary reason that mortality rates are so dismal. As with most other cancers, age is the primary risk factor for oral cancer. Though tobacco use is a major predisposing risk factor, **25% of oral cancer victims have no lifestyle risk factors.**

Oral Cancer Risk profile

Increased risk

- Patients age 40 and older (95% of all cases)
- 18-39 years of age combined with any of the following:
  - Tobacco use
  - Chronic alcohol consumption
  - Oral HPV infection

Highest risk

- Patients age 65 and older with lifestyle risk factors
- Patients with history of oral cancer

- **25% of oral cancers occur in people who don't smoke and have no other risk factors.**

We find that using ViziLite Plus along with a visual oral cancer examination improves our ability to identify suspicious areas that may have been missed during the conventional examination. Early detection of precancerous tissue can minimize or eliminate the potentially disfiguring effects of oral cancer and possibly save your life. ViziLite Plus is a painless exam that gives us a better chance to find any oral abnormalities you may have at an early stage.

Dental insurance might not cover the ViziLite Plus exam. However, this office is happy to verify your coverage for you and will also provide you with a medical insurance form for you to use to file this procedure with your medical insurance. The fee for this enhanced examination is $60.

Yes. I authorize the clinician to perform the ViziLite Plus exam along with the standard oral cancer examination. I accept financial responsibility for this enhanced examination.

Print name: ______________________________

Signature: ______________________ Date: ______________________

No. I would prefer not to have the ViziLite Plus exam at this time.

Print name: ______________________________

Signature: ______________________ Date: ______________________

To our Patients with Dental Insurance:

We would like to make you aware of some reimbursement policies with your insurance companies.

Concerning "White Fillings" on molars or posterior teeth:

Different Insurance plans have different reimbursement policies. Some will allow and pay for white fillings on molar teeth while some will not pay for white fillings on molar teeth. Placing white fillings would result in a larger out of pocket co-pay because they (insurance company) pay less for silver fillings than they pay for white fillings. The insurance company will down grade the billing code for the white filling to a silver filling based on their contractual obligation to your employer's dental insurance contract. The insurance company will fulfill their dental obligation as inexpensively as possible.

Here at Stahl Dental Studio, we do not place silver fillings containing mercury at all. We do not even stock the amalgam/ mercury mixture as it is classified as a toxic substance. If you do not want to pay for this additional out of pocket expense, please discuss this with the front desk as soon as possible, so that alternate treatment option or no treatment can be performed. We value our patient's health, and in Dr. Stahl's opinion, does not find mercury- containing fillings to be healthy for you.

Concerning Metal Crowns and Porcelain Crowns on Molars or Posterior Teeth:

The same dilemma exists with metal or porcelain crowns on molar teeth. Insurance Companies will downgrade our codes from porcelain crowns to metal crowns based on their contractual obligations to your employer. To prevent any additional out of pocket expense or any misunderstandings, we suggest a Pre- Determination of benefits prior to the start of treatment.

Please sign here as an acknowledgement that you read this statement. And understand it.

Date:____________________ Signature:____

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