HEALTH HISTORY

PATIENT NAME_____
Last **First** **Middle**

DATE OF BIRTH_____

Medical Doctor's name_____

Are you under a doctor's care now?_____ **Why?**_____

Have you been hospitalized during the past two years?____ **Why?**_____

Are you allergic to any medications or substance?____ **What?**_____

Please **CIRCLE** if you have had any of the following:

Abnormal Bleeding
AIDS or HIV Infection
Anemia
Arthritis
Asthma
Bleeding tendency
Blood transfusion, if yes, when_____
Bronchitis
Cancer/Chemo/Radiation Treatment
Cardiovascular disease:
- Arteriosclerosis
- Artificial heart valves
- Congenital heart defect
- Congestive heart failure
- Coronary heart valves
- Damaged heart valve
- Heart murmur
- Heart attack
- High blood pressure
- Low blood pressure
- Mitral valve prolapse
- Pacemaker
- Rheumatic heart disease/rheumatic fever

Alzheimer (dementia)
Tuberculosis
Cholesterol
Chest Pain
Chronic pain
Depression
Diabetes: Type 1, Type 2
Drug or Alcohol Abuse
Dry Mouth
Eating Disorder
Epilepsy
Fainting Spells
Gastrointestinal disease
G.E. Reflux/persistent heartburn
Glaucoma
Hemophilia
Hepatitis
Joint replacement
Kidney problems
Liver disease
Low blood sugar
Excessive urination
Ulcers
Malnutrition
Mental health disorders
Multiple Sclerosis
Neurological disorders
Neck or back pain
Night sweats
Osteoporosis
Persistent swollen glands
Recurrent Infections
Respiratory problems
Severe headaches/migraines
Seasonal allergies
Sexually transmitted disease
Sinus trouble
Sleep disorder
Sores or ulcers in mouth
Stroke
Systemic lupus erythematosus
Tobacco use
Thyroid problems

List any other medical conditions_____

List any medications currently taking_____

X_____ DATE_____
Patient Signature (Parent or Guardian)

DOCTOR_____ DATE_____

HEALTH HISTORY

DENTAL HISTORY

Do you have a specific dental problem?_____Describe_____

Do you have dental examinations on a routine basis?_____Last Visit_____

Would you describe your present dental health as good?_____Comments_____

Do you think you have active decay or gum disease?_____

Do your gums ever bleed?_____Discuss_____

Do you brush & floss on a routine basis?_____Discuss_____

Do you feel nervous about having dental treatment?_____

Have you ever had a bad experience in a dental office?_____Describe_____

Do you want to keep your remaining teeth?_____

Do you like your smile?_____Why_____

Name of previous dentist (optional)_____

Who referred you to our office?_____

MEDICAL UPDATES

I have read my MEDICAL & DENTAL HISTORY dated_____and confirm that it adequately states past and present conditions.

DATE	EXCEPTIONS	PATIENT'S SIGNATURE	REVIEWED BY
	None		Dr.
	None		Dr.
	None		Dr.
	None		Dr.
	None		Dr.

welcome

PATIENT NUMBER

Date _____

Patient's Name _____ Date of Birth _____ ❑ Male ❑ Female
Last First Initial

If Child: Parent's Name _____

How do you wish to be addressed _____
Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed ❑ Minor ❑

Residence - Street _____

City _____ State ____ Zip _____

Business Address _____

Telephone: Res. _____ Bus. _____

Fax _____ Cell Phone # _____

eMail _____

Patient/Parent Employed By _____

Present Position _____

How Long Held _____

Spouse/Parent Name _____

Spouse Employed By _____

Present Position _____

How Long Held _____

Who is Responsible for this account _____

Drivers License No. _____

Method of Payment: Insurance ❑ Cash ❑ Credit Card ❑

Purpose of Call _____

Other Family Members in this Practice _____

_____

Whom may we thank for this referral _____

Patient/Parent Social Security No. _____

Spouse/Parent Social Security No. _____

Someone to notify in case of emergency not living with you _____

_____

DENTAL INSURANCE 1ST COVERAGE

Employee Name _____ Date of Birth _____
Employer Name _____ Yrs. _____
Name of Insurance Co. _____
Address _____

_____
Telephone _____
Program or policy # _____
Social Security No. _____
Union Local or Group _____

DENTAL INSURANCE 2ND COVERAGE

Employee Name _____ Date of Birth _____
Employer Name _____ Yrs. _____
Name of Insurance Co. _____
Address _____

_____
Telephone _____
Program or policy # _____
Social Security No. _____
Union Local or Group _____

RELEASE:

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist.

I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.

I understand that my dental care insurance carrier or payor of my dental benefits may pay less that the actual bill for services. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental care payor.

I attest to the accuracy of the information on this page.

PATIENTS OR GUARDIAN'S SIGNATURE

_____

DATE _____

Control-o-fax Medical Systems of Triad Greensboro, NC Form No. 83-251217-2

Form No. T110R

REGISTRATION

Jon B. Byrd, DDS, PLLC

204 W. Lexington Ave.
High Point, NC 27262
Telephone: (336) 882-4412

Dear Patient,

Broken appointments and last minute cancellations cause the price of dental care to increase. There has been a consistent pattern of broken appointments and last minute cancellations in our practice recently. We understand that there are unexpected circumstances that we will take into consideration (sickness, family death, & etc.).

Failure to provide a 48-hour appointment cancellation notice will result in a fee of $25.00 charged to your account. Voicemail messages left after business hours previous to your appointment time on the next business day is considered a last minute cancellation and is less than 48-hour notice. We are sorry to take this course of action, but with the numerous broken appointments that have occurred, we are forced to handle the current situation in this manner.

Thank you for your confidence in our dental care,

Dr. Jon B. Byrd, DDS, PLLC

I HAVE READ AND UNDERSTAND THE BROKEN APPOINTMEN POLICY OF THIS OFFICE.

PATIENT'S OR GUARDIAN'S SIGNATURE

Signature:_____

Date:_____

JON B. BYRD, DDS, PLLC
ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

**** You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
(Please Print Name)

_____
(Signature)

_____
(Date)

With whom may your treatment be discussed?_____

With whom may your billing information be discussed?_____

Do you wish for us to leave detailed messages on answering machines? ___YES ___NO

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____