Heisch, Gartz and Cannon

106 Longview- Suite A • White Rock, NM 87547 (505)672-1336

Welcome to High Mesa Dental Arts

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

Title: _____ **Gender:** ○ Male ○ Female **Family Status:** ○ Married ○ Single ○ Child ○ Other
Mr/Ms/Mrs/etc

Birth Date: _____ **SS#:** ___-__-____ **Prev. Visit:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

The following is for: ○ the patient ○ the person responsible for payment ○ both ○ not applicable

Employer Name: _____ **Phone:** _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Whom may we thank for referring you to our practice?

_____

In an emergency who should be notified? Please enter Name and Phone number below:

_____

_____

Insurance Information

Primary Dental Insurance:

***ID Number is typically insurance holders social security number**

Name of Insured: _____ _____ ___
Last First MI

Insured's Birth Date: _____ **ID #:** _____ **Group #:** _____

Insured's Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Patient's relationship to insured: ○ Self ○ Spouse ○ Child ○ Other

Insurance Plan Name: _____

Insurance Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Insurance Authorization:

☐ **By checking this box,**
I authorize my insurance to pay my benefits directly to the dentist for all services rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges, whether or not paid by insurance.

☐ **By checking this box I acknowledge that High Mesa Dental Arts is a Premier Provider for Delta Dental, GEHA, and Cinga. All other insurance providers are considered out of network. We are NOT providers for medicaid or medicare.**

Secondary Dental Insurance

Name of Insured: _____ _____ ___
Last First MI

Insured's Birth Date: _____ **ID #:** _____ **Group #:** _____

Insured's Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Patient's relationship to insured: ○ Self ○ Spouse ○ Child ○ Other

Insurance Plan Name: _____

Insurance Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Medical History

Indicate which of the following you have had or have at present. By checking the box it will indicate a "Yes" response, leaving blank will indicate a "No" response.

- ☐ Alcoholism
- ☐ Allergy - Fentnal
- ☐ Allergy - Nuts
- ☐ Allergy- Tree Nuts
- ☐ A-polyethyleneglycol
- ☐ Asthma
- ☐ Blood Thinner
- ☐ cephalosporin
- ☐ Dementia
- ☐ EDS3 Hypermobility
- ☐ Fainting
- ☐ Hard of Hearing
- ☐ Heart Pacemaker
- ☐ Hip Replacment
- ☐ Knee Replacement
- ☐ Liver Transplant
- ☐ MCTD
- ☐ Multiple Sclerosis
- ☐ Organ Transplant
- ☐ Perio Surgery
- ☐ Radiation Treatment
- ☐ Shingles
- ☐ Stroke
- ☐ Use of Tobacco
- ☐ Allergy - All NUTS
- ☐ Allergy - Larazapam
- ☐ Allergy - Penicillin
- ☐ Allergy-LevoFloxacin
- ☐ Arthritis
- ☐ Autism
- ☐ Blood Transfusion
- ☐ Chemotherapy
- ☐ Dental Implant
- ☐ Endocarditis
- ☐ Fibromyalgia
- ☐ Head Injuries
- ☐ Heart Valve
- ☐ HIV
- ☐ lemons
- ☐ Low Blood Pressure
- ☐ Mental Disorders
- ☐ Mystenia Gravis
- ☐ Pacemaker
- ☐ Postural Tachydardia
- ☐ Respiratory Problems
- ☐ Shoulder Reconstruct
- ☐ Thyroid Disease
- ☐ Allergy Amoxicillin
- ☐ Allergy - Latex
- ☐ Allergy - Quinolones
- ☐ Alzheimer's
- ☐ Artificial Joints
- ☐ Behavior Problems
- ☐ Bruise Easily
- ☐ Cold Sores (Herpes)
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ hypothyroidism
- ☐ levaquin
- ☐ Lung Disease
- ☐ met Breast Cancer
- ☐ Naproxin
- ☐ Pain in Jaw Joints
- ☐ Pregnant / Nursing
- ☐ Seizures
- ☐ Sinus Problems
- ☐ Tuberculosis
- ☐ Allergy - Clindamyci
- ☐ Allergy - Narcotics
- ☐ Allergy- tomatoes
- ☐ Anemia
- ☐ Artificial Valve (H)
- ☐ Blood Disease
- ☐ Cancer
- ☐ COPD
- ☐ Dizziness
- ☐ Excessive Bleeding
- ☐ Guillian Beret Syndr
- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lupus
- ☐ Migraines
- ☐ Narcotics Issue
- ☐ Parkinson's
- ☐ Psychiatric Tx
- ☐ Sensitive Teeth
- ☐ Sleep Apnea
- ☐ Tumors

If any condition or alert selected above needs further clarification, please explain below:

_____

_____

_____

Are you allergic or have you had any adverse reaction (i.e. itching, rash, swelling or hands, feet or eyes) to anymedications?

_____

_____

What is your estimate of your general health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Date of last physical examination and name of physician:

_____

_____

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment:

_____

_____

Are you taking any medications, supplements, and/or vitamins or have taken in the last two years? *
○ Yes ○ No

Please list any medications you are currently taking, one medication per line:

_____

_____

_____

_____

_____

☐ ***By checking this box, I acknowledge that the above information is correct and I understand it is my responsibility to inform the office of any changes in my health as soon as possible.**

Dental Information

How would you rate the condition of your mouth?
☐ Excellent ☐ Good ☐ Fair ☐ Poor

Previous Dentist name and how long you have been a patient there:

_____

_____

Date of most recent dental exam: _____ **Date of most recent dental x-rays:** _____

I routinely see my dentist every:
☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

What is your immediate concern?

_____

_____

Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) _____

Personal History, Check all that apply:

☐ Had an unfavorable dental experience
☐ Had trouble getting numb
☐ Had/have braces, orthodontic treatment
☐ Had any teeth removed
☐ Had complications from past dental treatment
☐ Had any reactions to local anesthetic
☐ Had your bite adjusted

Smile Characteristics, Check all that apply:

☐ Is there anything about the appearance of your teeth that you would like to change?

☐ Have you ever whitened (bleached) your teeth?

☐ Have you felt uncomfortable or self conscious about the appearance of your teeth?

☐ Have you been disappointed with the appearance of previous dental work?

Bite and Jaw Joint, Check all that apply:

☐ You have problems with your jaw joint

☐ You have any problems chewing

☐ Your teeth changed in the last 5 years, become shorter, thinner, or worn

☐ Your teeth crowding or developing spaces

☐ You chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits

☐ You clench you teeth in the daytime or make them sore

☐ You have problems with sleep or wake up with an awareness of your teeth

☐ You wear or have worn a bite appliance

Tooth structure, Check all that apply:

☐ Cavities within past 3 years

☐ The amount of saliva in your mouth seems too little or you have difficulty swallowing any food

☐ You notice or have holes (i.e. pitting, craters) on the biting surface of your teeth

☐ Any teeth sensitive to hot, cold, biting, sweets, or you avoid brushing any part of your mouth

☐ Any teeth with grooves, notches, chips, a cracked filling or pain

☐ Food gets caught between any teeth

Gum and Bone, Check all that apply:

☐ Gums bleed when brushing or flossing

☐ Treated for gum disease or were told you have lost bone around your teeth

☐ Noticed an unpleasant taste or odor in your mouth

☐ History of periodontal disease in your family

☐ Experienced gum recession

☐ Had any teeth become loose on their own (without injury), or have difficulty eating an apple

☐ Experienced a burning sensation in your mouth

If any of the checked boxes need further explanation, please describe:

_____

_____

_____

_____

_____

Consent for Services and Financial Policy

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at

the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 120 days, unless previously written financial arrangements are satisfied.

I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

☐ * **By checking this box, I understand the above information and agree with its contents. This will serve as my electronic signature for the Administration Form.**

HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality,

☐ **By checking this box, I understand the above information and agree with its contents. This will serve as my electronic signature for the HIPAA Disclosure Form.**

Response Date: _____