Ross Dental Group

Something To Smile About

Ross Dental Group
3825 Kraus Lane, Unit J
Fairfield, OH 45014
513-738-2606

HEALTH HISTORY

Today's Date_____

Patient First Name_____ Middle_____ Last _____ Preferred Name _____

Date of Birth_____SSN _____ Driver's Lic. #_____

Address _____

CIty _____ State _____Zip_____

Patient Employed by _____Occupation _____

Gender_____ Age _____ Marital Status: Single Married Widowed The Patient is a Dependent Child

Is patient a full time college student? Yes No If so where? _____

If you are a new patient, how did you hear about us? Location Insurance Patient Other _____

Home Phone_____ Work Phone_____ Cell Phone_____ Text: yes / no

E-mail Address _____

Who may we contact in case of an emergency? _____ Relationship _____ Phone_____

Dental Insurance Information:

Please select one of the following: **____ I do not have dental insurance.**

____ My dental insurance has changed. (Please alert the front desk before being seen.)

____ No, my insurance has not changed since my last visit here.

Primary Dental Insurance Carrier _____ Employer _____

Name of Policyholder _____ DOB _____Relationship to Patient _____

Member ID # _____Group # _____Phone _____

Policy Holder SSN: _____

Secondary Dental Insurance Carrier_____Employer _____

Name of Policyholder _____ DOB _____Relationship to Patient _____

Member ID # _____ Group #_____Phone _____

Policy Holder SSN: _____

Have you used any dental benefits **outside** of our office this year? Yes No If yes, where? _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is the gateway to the rest of your body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care for any specific medical condition? Yes No If yes, explain:_____

Have you recently been hospitalized or had a major operation? Yes No If yes, explain:_____

Have you recently had a serious head or neck injury? Yes No If yes, explain:_____

Have you ever taken any bone enhancing medications containing bisphosphonates such as Fosamax, Boniva or Actonel? _____When were they taken? _____

Are you taking any medications? Yes No If yes, please list all medications even over the counter medications. ☐ See Scanned List _____

_____

Do you take blood thinners or a daily aspirin? Yes No

(OVER PLEASE)

Do you use tobacco? Smoke Dip Chew Yes No If yes, how much:_____

Does your surgeon prescribe an antibiotic for you to take prior to your dental appointments?_____

What is the name and phone number of your pharmacy should we ever need to call in any medications for you?

_____

Women:

☐ Pregnant: Due Date:_____ ☐ Not Pregnant ☐ Nursing ☐ Taking Any Kind of Contraceptives: If yes, please explain:

_____

Are you allergic to any of the following?

☐ **No Known Allergies**	☐ Latex	☐ Codeine	☐ Acrylic
☐ Aspirin	☐ Penicillin	☐ Sulfa drugs	☐ Local Anesthetics
☐ Metal/Nickel	☐ Amoxlcillin		

Other? Yes No If yes, Explain_____

Circle all that apply:

ADD/ADHD
Acid Reflux
AIDS/HIV Positive
Alzheimer's Disease
Anaphylaxis/Severe Allergic Reaction
Angina/Chest Pains
Arthritis
- Osteo
- Rheumatoid Arthritis

Artificial Heart Valve
Artificial Joint
- Surgery date_____
- Which joint_____

Asthma
Blood Disease
Bruise Easily
Cancer
- What kind?_____
- When? _____

Chemotherapy/Radiation
- When?_____

Chest Pains
Cold Sores/Fever Blisters
COPD
Cortisone Medicine (Past or Present)
Dementia
Diabetes Type I
Diabetes Type II
Drug Addiction
Dry Mouth
Emphysema
Epilepsy or Seizures
Excessive Bleeding
Fainting Spells/Dizziness/ Vertigo
Frequent Headaches
Glaucoma
Heart Murmur

Heart Pacemaker
Heart Trouble/Disease/Heart Attack
Hemophilia
Hepatitis A
Hepatitis B or C
Herpes
High Blood Pressure
High Cholesterol
Hives or Rash
Hyperglycemic
Hypoglycemia
Irregular Heartbeat/Afib
Kidney Problems
Low Blood Pressure
Lung Disease
Migraines
Mitral Valve Prolapse
Osteoporosis
Pain in Jaw Joints

Parkinsons
Psychiatric Care
Rheumatic Fever
Shingles
Sleep Apnea
Sinus Trouble/Seasonal Allergies
Stomach/Intestinal Disease/IBS
Stroke
Thyroid Disease
- Hypothyroidism
- Hyperthyroidism
- Parathyroid Glands

Tonsillitis
Tuberculosis
- Active or Inactive?

Tumors or Growths

Have you ever had any serious illness or condition not listed? Yes No If yes explain _____

Consent for Services: I understand that I am financially responsible for all charges whether or not paid or allowed by insurance. As a condition of your treatment by this office, note that payment is due at the time of service. Patients with dental insurance will be asked to pay their estimated portion at the time of service. As a courtesy our office will submit claims to your dental insurance company on your behalf. You are responsible for notifying the office about changes to your insurance policy. Predeterminations are only done at the patient's request. Predeterminations do not guarantee benefits.

Your signature below gives Ross Dental Group permission to release to your insurance company all information necessary to secure the payment of b-enefits. It also serves as authorization for your insurance company to pay this office for all benefits otherwise payable to you for services rendered and to use this signature on all insurance submissions.

HIPAA: Notice of our HIPAA Privacy Policy is clearly posted in our reception room as mandated by law. Your signature on this form is your acknowl edgement of that. If you would like a written copy of our specific HIPAA policies, please ask an administration member of our team.

Cancellation fee: Our office requires that a 48 hour business notice be given for cancellation of an appointment. If appropriate notice is not given, a fee of $75.00 per appointment can be assessed for late cancellation and broken appointments.

Signature Of Patient, Parent, or Guardian: _____ **Date:** _____

Patients Printed Name: _____