Health Centered Dentistry

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New Patient Information

Please take a minute to fill in the following information for our records:

LAST NAME: ___________________________ FIRST NAME: ________________________________

TITLE: ____________ MIDDLE NAME: ________________ NICK NAME: ____________________

ADDRESS: ____APT #: ____________

CITY: _______________________________ STATE: _____________ ZIP: _____________________

BIRTH DATE: _____/_____/________ MARITAL STATUS: ______________ SEX: ____________

HOME PHONE: (   ) ___________________ WORK PHONE: (   ) ______________________

CELL PHONE: (   ) ___________________ EMPLOYER: ________________________________

OCCUPATION: ____________________ SPOUSE / PARENT OCCUPATION: ___________________

WEB SITE: _________________________________ E-MAIL: _________________________________

EMERGENCY CONTACT: ___________________ PHONE #: (   ) __________________________

MEDICAL ALERTS: ____

____

____

REFERRED BY (How did you hear about us?): ____

I give permission to the doctors of Health Centered Dentistry to monitor progress as well as provide therapy, and teach Neuromuscular relaxation therapy techniques (reducing restriction to proper motion) above and below the dental region for the purpose of reduction of dental stress on the musculoskelatal system throughout the body. I understand Dr. Laughlin has continued education and experience in the field of Deep Muscle Therapy and realize the need of this approach for reduction of muscle tension throughout the body including the TMJ. I further give the doctors permission to consult (in regards to my health care) with other health care providers, insurance companies, attorneys, and other professionals who may be able to provide information that may be pertinent to my condition. I also give permission to Health Centered Dentistry to use my Study Models, Photographs, Slides, X-rays, and other case documentation, for demonstration and education purposes which may include published articles, books, magazines, seminars, or multimedia publications. Phone numbers and addresses will not be disclosed without additional consent.

____
Patients Full Name

___________________________________ ________________
Patient or Legal Guardian's Signature Date

PLEASE COMPLETE BOTH SIDES OF THIS SHEET ....THANK YOU.

Health Centered Dentistry

John D. Laughlin III, D.D.S.

Payment Policy

Payment Guidelines for Services Provided:

We have a simple policy regarding payment for the health care we are providing.

Payment by CASH, CHECK, or CREDIT CARD is due on the day of service.
Payment plans may be available after your first initial appointment.

We do want you to be aware that we assess finance charges of 1.5% per month (18% per year) on overdue accounts. We also charge for late cancellations and broken appointments.

I understand I am financially responsible to Dr. John D. Laughlin III for all charges incurred.

PAYMENT IN FULL IS ALWAYS EXPECTED ON THE DAY OF SERVICE.
(unless alternative arrangements have been made prior)

SIGNATURE: ____
(SIGNATURE OF RESPONSIBLE PAYER)

Insurance

If you have dental insurance, please provide us your dental insurance card at your first visit. We will submit your dental claim to your dental insurance for you. Your insurance company will then reimburse you directly.

Health Centered Dentistry is not a part of any insurance network and therefore is considered "out of network" coverage.

We do not submit to medical insurance.

We are unable to accept/submit medical assistance or Medicare.

Health History Form

NAME (please print): ______________________ DATE: __________

Please answer the following questions to help us understand your unique perspectives, priorities, and concerns. You can be assured this information is held in confidence.

1. What would you like us to help you with? ______________________

____

____

2. Do you need to be premedicated (before dental procedures)? ☐ Yes ☐ No
   If so, what medication(s)? ______________________
3. Are you accustomed to seeing a dentist on a regular basis? ☐ Yes ☐ No
4. Please rate your comfort level with receiving dental treatment.
   ☐ No Problem ☐ Slightly Uneasy ☐ Moderately Anxious ☐ Wild Horses Have To Drag Me In

CHECK THE MOST APPROPRIATE BOXES

My ☐ mouth is very comfortable ☐ mouth is moderately comfortable ☐ mouth is uncomfortable	I ☐ think my dental health is excellent ☐ think my dental health is good ☐ think my dental health is poor
I ☐ have set goals for my dental health ☐ have never set goals for my dental health ☐ want to set goals for my dental health	I ☐ am able to chew all types of food comfortably ☐ have difficulty chewing some foods ☐ have difficulty chewing most hard or crunchy foods
I ☐ think the appearance of my mouth is excellent and would change nothing ☐ think the appearance of my mouth is satisfactory ☐ think the appearance of my mouth is unsatisfactory ☐ I desire whiter teeth ☐ I desire straighter teeth	I ☐ have generally chosen the highest quality dental option offered ☐ have generally based my treatment choices on the initial cost ☐ have rarely gone to the dentist and not completed treatment discussed
I ☐ hope for excellent dental health and repair ☐ would like good dental health and repair ☐ desire urgent care only	I ☐ am familiar with Holistic Dentistry and its importance ☐ am open to the possiblities of Holistic Dentistry ☐ am only interested in general dental care

5. Please describe any problems you have had with past dental experiences. ______________________

____

____

6. Who are the alternative healthcare providers you have seen, and for what therapies? ______________________

____

____

7. Who is your primary Medical Doctor / Health Care Provider? ______________________

   Practitioner's Phone Number: (   ) __________ When was your last check-up? __________
8. Please list any hospitalizations / surgeries you have had. ______________________

____

9. Please list any prescribed or over the counter medications and food supplements (vitamins, minerals, glandulars) you take regularly (specify the amount). ______________________

____

10. Please describe any exercise you do 3 or more times per week. ______________________

____

PLEASE [X] THOSE THAT APPLY

NOW PAST

DIGESTIVE
- ___|___ Ulcers
- ___|___ Crave salt
- ___|___ Gall bladder
- ___|___ Low blood sugar
- ___|___ Glaucoma
- ___|___ Diabetes
- ___|___ Brittle fingernails
- ___|___ Arthritis
- ___|___ Hyperactivity
- ___|___ Excessive hair loss

NEUROLOGICAL
- ___|___ Shaking or twitching
- ___|___ Muscle spasms
- ___|___ Polio
- ___|___ Seizures
- ___|___ Heavy metal toxicity
- ___|___ Dizziness
- ___|___ Memory loss
- ___|___ Nervousness
- ___|___ Epilepsy
- ___|___ Numbness of fingers
- ___|___ Parkinson's disease
- ___|___ Cerebral Palsy
- ___|___ Multiple Sclerosis
- ___|___ Fainting spells

BEHAVIOR / DEVELOPMENTAL
- ___|___ ADD (Attention Deficit Disorder)
- ___|___ ADHD (Attn Def Hyperactivity Dis)
- ___|___ Learning disability
- ___|___ Autism
- ___|___ Mental disability

EMOTIONAL / PSYCHOLOGICAL
- ___|___ Emotional upsets
- ___|___ Perfectionist
- ___|___ Depression
- ___|___ Physical, mental, and / or emotional stress
- ___|___ Lose temper easily
- ___|___ Often moody
- ___|___ Schizophrenia
- ___|___ Psychological care

CARDIOVASCULAR / BREATHING
- ___|___ Poor circulation
- ___|___ Anemia
- ___|___ Frequent nose bleeds
- ___|___ Arteriosclerosis
- ___|___ Heart problems (specify): ____________
- ___|___ Stroke (When): ____________
- ___|___ Previous Heart-Attack / Surgery
  When: ____________
  What: ____________
- ___|___ Angina (Chest Pain)
- ___|___ Abnormal blood pressure
  Hl~ Low~ (circle one)
- ___|___ Swollen ankles / hands
- ___|___ Asthma / Hay-fever
- ___|___ Shortness of breath / Breathing difficulties
- ___|___ Emphysema
- ___|___ Sleep disturbances
- ___|___ Sleep Apnea / Day Apnea
- ___|___ Sleep Study Performed / Recmd
- ___|___ Mouth breathing
- ___|___ Swallowing problems

NOW PAST

IMMUNE SYSTEM ISSUES
- ___|___ Mononucleosis
- ___|___ Frequent colds
- ___|___ Frequent fevers
- ___|___ Lupus
- ___|___ Tuberculosis
- ___|___ Chemically sensitive
- ___|___ Cancer (Type): ____________
  When diagnosed: ____________
  Treatments Performed: ____________
  Current Status: ____________
- ___|___ Pneumonia
- ___|___ Hepatitis
- ___|___ Candida infection (yeast, thrush)
- ___|___ Venereal disease
- ___|___ Thyroid Problems
- ___|___ Slow healing
- ___|___ Tonsilitis
- ___|___ HIV / AIDS (Aquired Immune Deficiency Syndrome)
- ___|___ Skin rash
- ___|___ Liver issues
- ___|___ Bleeding gums
- ___|___ Cold sores
- ___|___ Shingles
- ___|___ Chronically tired
- ___|___ Sore mouth

STRUCTURAL ISSUES
- ___|___ Chronic stiff neck
- ___|___ Shoulder pain
- ___|___ TMD / TMJ (Temporo Mandibular Joint Dysfunction)
- ___|___ Grinding of teeth
- ___|___ Clenching jaws
- ___|___ Headaches
  How Often: ____________
  Severity of Pain (1-10): ____
  What activities are you not able to do during the pain? ____________
- ___|___ Back pain (upper, middle, lower)
- ___|___ Scoliosis
- ___|___ Sinus problems
- ___|___ Hearing loss
- ___|___ Frequent ear infections

NOW PAST

- ___|___ Orthodontics
- ___|___ Speech problems
- ___|___ Ringing in ears
- ___|___ Neck injury / operation
- ___|___ Artificial joints / bones

OTHER
- ___|___ 3 (or more) hours of tv daily
- ___|___ Dental cavities
- ___|___ Bad breath / Unpleasant taste in mouth
- ___|___ Metallic taste in mouth
- ___|___ Muscle soreness
- ___|___ Night-time bathroom visits
- ___|___ Leg cramps
- ___|___ Kidney problems
- ___|___ Accidents / Injuries

FEMALE ONLY
- ___|___ Pregnant (due date): ____________
- ___|___ Nursing Mother
- ___|___ PMS
- ___|___ Birth control
- ___|___ Menopausal problems
- ___|___ Hormonal imbalance

ALLERGIES:
- ___|___ Penicillin
- ___|___ Tetracycline
- ___|___ Erythromycin
- ___|___ Aspirin
- ___|___ Codeine
- ___|___ Dental anesthetics
- ___|___ Latex
- ___|___ Other: ____________
- ___|___ ____________

RECREATIONAL DRUG USE
- ___|___ Nicotine: cig / per day ____
  cigars per day ____
- ___|___ Alcohol
- ___|___ Marijuana
- ___|___ Cocaine
- ___|___ Caffeine (coffee or sodas)
- ___|___ Pipe (tobacco)
- ___|___ Chewing tobacco
- ___|___ Other: ____________

COUNSELING / HISTORY OF
- ___|___ Alcohol dependence
- ___|___ Chemical dependence (prescription and/or street drugs)

MEDICATION / DRUG / PHARMACEUTICAL USAGE

NOW PAST

- ___|___ Thyroid Medication ____________
- ___|___ Diabetes Medications ____________
- ___|___ Blood Pressure Medication ____________
- ___|___ Heart Medication ____________
- ___|___ Muscle Relaxants ____________
- ___|___ Anti-Depressants ____________
- ___|___ Pain Medications ____________
- ___|___ Antibiotics ____________
- ___|___ Digestive/Stomach Medication ____________
- ___|___ Cortisone ____________
- ___|___ Aspirin ____________
- ___|___ Over The Counter Medications ____________
- ___|___ Other Medications ____________

SIGNATURE : ____________ DATE: ____________

New Patient Information Contd.

Please take a minute to fill in the following information for our records:

REFERRED BY (How did you hear about us?): ___________________________

REFERRED FOR (CHECK THOSE THAT APPLY):

GENERAL DENTISTRY ________

TMJ (Jaw Joint) THERAPY ________

ORTHOPEDIC ORTHODONTICS ________

RESTORATIONS ________
(INVOLVING PREVIOUSLY PLACED AMALGAM FILLINGS)

SLEEP / DAY APNEA (Airway) ANALYSIS ________

Are you having any pain now? ___________________________

Where is the pain? ___________________________

Rate your pain from 0 - 10: ___________________________

How long have you been having pain? ___________________________

Who is currently taking care of your Dental needs? ___________________________

What was your dentist's opinion of this problem ___________________________

____

What is the reason you want to become a patient at Health Centered Dentistry? ________

____

What do you know about our office philosophy? ___________________________

____

____

Let me tell you about our office. We are a holistic office. We have not used amalgam fillings for over 22 years. We use the finest bio-compatible materials. We treat many patients who are highly sensitive to environmental pollutants. Please refrain from wearing perfumes and / or colognes when you visit our office.

In an effort to hold down the cost of dentistry to you and all our other patients, we limit our billing processes. You may pay for your treatment by cash, check or credit card. Payment is always expected on the date of service.

Do you have any other questions? ___________________________

____

____

____