



# Health Centered Dentistry

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

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

NOW PAST

**MEDICATION / DRUG / PHARMACEUTICAL USAGE**

- 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? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

