Health Centered Dentistry

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New Patient Information

LAST NAME: _____ FIRST NAME: _____

TITLE: _____ MIDDLE NAME: _____ PREFERRED NAME: _____

ADDRESS: _____ APT #: _____

CITY: _____ STATE: _____ ZIP: _____

BIRTH DATE: _____ MARITAL STATUS: _____ GENDER: _____

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

Health Centered Dentistry

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

Payment Policy

Payment Guidelines for Services Provided:

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. Do you usually see a dentist for routine cleanings and exams? ☐ 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 ☐ have generally chosen the highest quality dental option offered ☐ have generally based my treatment choices on the initial cost ☐ mostly don't complete the dental treatment that has been recommended
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

- IBS (Irritable Bowel Syndrome)
- Crohn's Disease
- Ulcers
- Crave salt
- Gall bladder
- Low blood sugar
- Glaucoma
- Diabetes
- Brittle fingernails
- Arthritis
- 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
- ADHD
- Learning disability
- Autism
- Mental disability
- Hyperactivity

EMOTIONAL / PSYCHOLOGICAL

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

CARDIOVASCULAR / BREATHING

- Poor circulation
- Anemia
- Frequent nose bleeds
- Arteriosclerosis
- Heart problems (specify): _____
- Stroke (When): _____
- Previous Heart-Attack / Surgery
  - When: _____
  - What: _____

NOW PAST

- 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
- Tongue / Lip tie release
- Myofunctional Therapy

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
- 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?

NOW PAST

- Back pain (Circle applicable) Upper - Middle - Lower
- Scoliosis
- Sinus problems
- Hearing loss
- Frequent ear infections
- Orthodontics
- Speech problems
- Ringing in ears
- Neck injury / operation
- Artificial joints / bones

OTHER

- 3 (or more) hours of screen time 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
- Breast Implant(s)

ALLERGIES:

- Penicillin
- Tetracycline
- Erythromycin
- Aspirin
- Codeine
- Dental anesthetics
- Latex
- Other: _____

RECREATIONAL DRUG USE

- Nicotine:
  - cig / per day ____
  - cigars / per day ____
- Vaping
- Alcohol
- Marijuana
- Cocaine
- Caffeine (coffee or sodas)
- Pipe (tobacco)
- Chewing tobacco
- Other: _____

COUNSELING / HISTORY OF

- Alcohol dependence
- Chemical dependence (prescription and/or street drugs)

Health History / New Patient Information Contd.

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 / Ibuprofen / Tylenol	_____
___	___	Over The Counter Medications	_____
___	___	Other Medications	_____

SIGNATURE : _____ DATE: _____

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? _____

_____

_____

We treat many patients who are highly sensitive to enviornmental 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 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.