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202-737-7025

Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)
 Gender: _____ Family Status: _____
 Social Security #: _____ Birth Date: _____
 Phone (Home): _____ (Work): _____ Ext: _____ Cell: _____
 E-mail Address: _____ May we contact you by e-mail Yes No
 Address: _____
Street Apartment #

City State Zip Code

Health Information

Have you ever had any of the following? Please check those that apply:

- | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> AIDS
<input type="checkbox"/> Abnormal Bleeding Tendencies

<input type="checkbox"/> Allergy Codeine
<input type="checkbox"/> Allergy Penicillin
<input type="checkbox"/> Allergy Latex
<input type="checkbox"/> Allergy Metals
<input type="checkbox"/> Allergy Rubber
<input type="checkbox"/> Allergy Other

<hr/>
<hr/>
<hr/>
<input type="checkbox"/> Anemia
<input type="checkbox"/> Arthritis
<input type="checkbox"/> Artificial Joints
<input type="checkbox"/> Asthma
<input type="checkbox"/> Blood Disease
<input type="checkbox"/> Blood Transfusions
<input type="checkbox"/> Breathing Difficulties
<input type="checkbox"/> Bronchitis
<input type="checkbox"/> Birth Control Pills

<input type="checkbox"/> Cancer
<input type="checkbox"/> Chronic Cough
<input type="checkbox"/> Chemotherapy
<input type="checkbox"/> Cirrhosis
<input type="checkbox"/> Colitis
<input type="checkbox"/> Coronary artery disease
<input type="checkbox"/> Diabetes
<input type="checkbox"/> Dizziness
<input type="checkbox"/> Earaches/ringing in ears
<input type="checkbox"/> Emphysema | <input type="checkbox"/> Excessive Bleeding
<input type="checkbox"/> Fainting
<input type="checkbox"/> Fever Blister/Cold Sores
<input type="checkbox"/> Gastritis
<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Growths
<input type="checkbox"/> Hay Fever
<input type="checkbox"/> Head & Neck Radiation

<input type="checkbox"/> Head Injuries
<input type="checkbox"/> Hearing Loss
<input type="checkbox"/> Heart Attack
<input type="checkbox"/> Heart Disease
<input type="checkbox"/> Heart Murmur
<input type="checkbox"/> Heart & Valve defects
<input type="checkbox"/> Hepatitis
<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> HIV Positive
<input type="checkbox"/> Jaundice
<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Liver Disease
<input type="checkbox"/> Mitral Valve Prolapse
<input type="checkbox"/> Mental Disorders
<input type="checkbox"/> Nervous Disorders
<input type="checkbox"/> Oral Cancer/Tumor
<input type="checkbox"/> Pacemaker
<input type="checkbox"/> Prosthetic Heart
<input type="checkbox"/> Prosthetic Joint(s)
<input type="checkbox"/> Pregnancy
Due date: _____
<input type="checkbox"/> Psychiatric Treatment

<input type="checkbox"/> Radiation Treatment
<input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Rheumatism
<input type="checkbox"/> Severe Headaches
<input type="checkbox"/> Sexually Transmitted Disease
<input type="checkbox"/> Sinus Problems
<input type="checkbox"/> Stomach Problems
<input type="checkbox"/> Stroke
<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Tumors
<input type="checkbox"/> Ulcers
<input type="checkbox"/> Urinate frequently
<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Illegal Drugs

OTHER:
<input type="checkbox"/> _____
<input type="checkbox"/> _____ |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

Medical History

INSTRUCTIONS:

“I understand that honest answers to the questions stated below are important to the provision of my dental care, and that I will answer them to the best of my ability. I have been informed that if I am uncertain about the question or how the question related to my health status, I must discuss the problem with the doctor or a member of the office staff. I understand that all questions must be answered. I have been assured that the information I provide will not be released without my express permission.”

patient's initials _____ dentist's initials _____

To receive treatment in this office you must answer all questions on this history form.

The questions asked relate directly to the safe and effective treatment you are to receive in the office – to the best of your ability honest answers must be given.

If you are unsure of the question, unsure of your answer, or whether the question relates to your medical condition, you are to discuss the matter with the doctor.

Some of the questions may not relate to you or your medical condition; in that event you are to write “N/A” (not applicable) in the space provided.

All questions must be answered and written in ink.

To properly evaluate your current health status it may be necessary for the dentist to contact your physician. Included on this form is “Permission to Release Information.” You are asked to sign it in the presence of a member of the office staff.

ALL INFORMATION YOU SUPPLY TO THE OFFICE ON THIS FORM, AND THE SUBSEQUENT INTERVIEW BY THE DENTIST AND INFORMATION RECEIVED FROM YOUR PHYSICIAN OR ANY OTHER SOURCE, WILL BE HELD IN THE STRICTEST CONFIDENCE, AND WILL NOT BE DISCLOSED WITHOUT YOUR EXPRESS AND WRITTEN PERMISSION.

- 1. Name, address & phone # of your physician _____
- 2. Date of last visit to your doctor _____ purpose of visit _____
- 3. Do you suffer from any disability? _____ if yes, describe _____
- 4. Have you ever, or do you now take illegal drugs? _____ if yes, what drugs, and when taken? _____

Note: There are drugs and medications used in routine dental care that are incompatible with several illegal drugs. The effect of the combination may be dangerous to your health and may be fatal.

- 5. Do you have AIDS, or are you HIV-positive? _____ If yes, describe and provide current status. _____
- 6. Do you now have, or have you ever had a venereal disease? _____ If yes, describe. _____
- 7. Have you ever had, or do you now have hepatitis? _____ If yes, describe. _____
- 8. For females: Are you pregnant? _____ if yes, when are you due? _____
- 9. For females: Are you taking birth control pills? _____ Note: There are drugs and medications used in routine dental care that decrease the effectiveness of birth control pills.
- 10. List all medications you are now taking or have taken previously on a regular basis, describe the strength and purpose for each.

Note: There are many drugs and medications when mixed with other drugs and/or medications may cause complications, some of which may result in dangerous health problems. Information about your current use of drugs and medications is essential.

- 11. Have you ever had an allergic reaction to medication? _____ If yes, describe. _____
- 12. Have you lost weight recently? _____ If yes, describe. _____

Have You Ever Had Or Been Treated For:

- 13. Rheumatic fever, rheumatic heart disease, heart murmur or congenital heart disease? _____
- 14. Heart trouble, heart attack, angina, heart surgery, a pacemaker, or irregular beats? _____
- 15. Stomach or intestinal disease? _____
- 16. Abnormal blood pressure, excessive bleeding, or anemia? _____ - _____
- 17. Breathing problems, asthma, tuberculosis, or hay fever? _____
- 18. Cancer, X-ray treatments, chemotherapy, or IV bisphosphonate (i.e. Zometa or Aredia) treatment? _____
- 19. Diabetes? _____

Medical History (continued)

21. A stroke, convulsions, or fainting spells? _____
22. Tumors or growths? _____
23. Arthritis or rheumatism? _____
24. Have you ever had a major operation? _____ If yes, describe. _____
25. Have you ever had a serious injury to your head or neck? _____ If yes, describe. _____
26. Are you on a special diet? _____ If yes, for what reason and describe. _____
27. Do you smoke? _____ If yes, describe type and quantity. _____
28. Have you consulted or been treated by a psychiatrist, psychologist, or counselor? _____ If yes, when and describe. _____
29. Do you consume any alcoholic beverages? If yes, how much and how often? _____
30. Are there any other problems about your health of which you are aware? _____
31. For children under 10 years old: Was the child born by Cesarean Section? _____
32. Females: Are you currently taking any bisphosphonate medication? _____
33. Have you had any prosthetic joint replacement? _____
34. Are you allergic to latex? _____
35. Do you ever notice that your feet and/or ankles are swollen? _____
36. Are you aware of any swollen glands in your neck? _____

Dental History

1. Name of previous dentist _____ date of your last visit _____
2. Reason for your last visit (or series of visits) _____
3. Do you have any of your X-rays or dental records? _____
4. Chief dental complaint if any? _____
- In respect to any previous dental treatment have you:***
5. Ever fainted? _____
6. Had an allergic reaction? _____
7. Had abnormal bleeding? _____
8. Any other complications during or following dental treatment? _____ If yes, describe. _____
9. Do your gums bleed on brushing or eating? _____
10. Does food catch between your teeth? _____
11. Have your teeth shifted, are there spaces between your teeth now where there were none, are your teeth flaring, or are some of your teeth becoming loose? _____
12. Are any of your teeth sensitive to heat, cold, or pressure? _____
13. Do you grind your teeth or clench your jaws? _____
14. Do you have pain or clicking in the jaw joint in front of your ear? _____
15. Have your jaw muscles ever been sore? _____ If yes, describe. _____
16. Are there any sores or growths in your mouth? _____
17. Do any of your teeth ache? _____
18. Do you have any other dental complaint? _____

Nearest relative to contact in case of emergency: _____ Phone# _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____

Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? Another patient, friend Another patient, relative
 Dental Office Yellow Pages Newspaper School Work Other _____

Name of person or office referring you to our practice: _____

Spouse or Responsible Party Information

The following is for: the patient's spouse the person responsible for payment

Name: _____
 Male Female Married Single Child Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #
City State Zip Code

Employment Information

The following is for: the patient the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City, State Zip Code Phone

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? Yes No

Last First MI
 Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

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

Insurance Plan Name and Address: _____

Secondary

Name of Insured: _____ Is insured a patient? Yes No

Last First MI
 Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

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

Insurance Plan Name and Address: _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and 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.

Patients who carry dental insurance understand that all dental services furnished 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 patients insurance forms or assist in making collections from insurance companies and will credit any such 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 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed 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, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. 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 at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party

Insurance Consent

In order for us to help prepare your insurance forms and assist in making collections from insurance companies to credit to your account, we will need the following authorizations: I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with my claims:

X _____
Signature of Responsible Party/Parent or Guardian

I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly Andrea S. Flamer, D.D.S.

X _____
Signature of Responsible Party/Parent or Guardian