

Health History Form

Email: _____ Today's Date: _____

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: _____ <small>Last First Middle</small>			Home Phone: <i>Include area code</i> () ()	Business/Cell Phone: <i>Include area code</i> () ()
Address: _____ <small>Mailing address</small>			City: _____	State: _____ Zip: _____
Occupation: _____	Height: _____	Weight: _____	Date of Birth: _____	Sex: M F
SS# or Patient ID: _____	Emergency Contact: _____	Relationship: _____	Home Phone: <i>Include area code</i> () ()	Cell Phone: <i>Include area code</i> () ()
If you are completing this form for another person, what is your relationship to that person? <small>Your Name Relationship</small>				
Do you have any of the following diseases or problems: <i>(Check DK if you Don't Know the answer to the question)</i>				
Active Tuberculosis				Yes No DK <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Persistent cough greater than a 3 week duration				<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Cough that produces blood				<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Been exposed to anyone with tuberculosis				<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.				

Dental Information Please mark (X) your responses to the following questions.

Do your gums bleed when you brush or floss?	Yes No DK <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you have earaches or neck pains?	Yes No DK <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Are your teeth sensitive to cold, hot, sweets or pressure?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you have any clicking, popping or discomfort in the jaw?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Is your mouth dry?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you brux or grind your teeth?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Have you had any periodontal (gum) treatments?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you have sores or ulcers in your mouth?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Have you ever had orthodontic (braces) treatment?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you wear dentures or partials?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Have you had any problems associated with previous dental treatment?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you participate in active recreational activities?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Is your home water supply fluoridated?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Have you ever had a serious injury to your head or mouth?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Do you drink bottled or filtered water?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Date of your last dental exam: _____	What was done at that time? _____
If yes, how often? <i>(Check one)</i> DAILY <input type="checkbox"/> / WEEKLY <input type="checkbox"/> / OCCASIONALLY <input type="checkbox"/>		Date of last dental x-rays: _____	
Are you currently experiencing dental pain or discomfort?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		
What is the reason for your dental visit today? _____			
How do you feel about your smile? _____			

Medical Information Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

Are you now under the care of a physician?	Yes No DK <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Have you had a serious illness, operation or been hospitalized in the past 5 years?	Yes No DK <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Physician Name: _____	Phone: <i>Include area code</i> () ()	If yes, what was the illness or problem? _____	
Address/City/State/Zip: _____		Are you taking or have you recently taken any prescription or over the counter medicine(s)?	
Are you in good health?		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Has there been any change in your general health within the past year?		If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements: _____ _____ _____	
If yes, what condition is being treated? _____			
Date of last physical exam: _____			

Medical Information Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

(Check DK if you Don't Know the answer to the question)

Do you wear contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Do you use controlled substances (drugs)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK
Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Date: _____ If yes, have you had any complications? _____	Do you use tobacco (smoking, snuff, chew, bidis)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK If so, how interested are you in stopping? _____ Circle one: VERY / SOMEWHAT / NOT INTERESTED
Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax [®] , Actonel [®] , Atelvia, Boniva [®] , Reclast, Prolia) for osteoporosis or Paget's disease? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Do you drink alcoholic beverages? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK If yes, how much alcohol did you drink in the last 24 hours? _____ If yes, how much do you typically drink in a week? _____
Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia [®] , Zometa [®] , XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Date Treatment began: _____	WOMEN ONLY Are you: Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Number of weeks: _____ Taking birth control pills or hormonal replacement? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Nursing? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK
Allergies. Are you allergic to or have you had a reaction to: To all yes responses, specify type of reaction.	
Local anesthetics <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Metals <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK
Aspirin <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Latex (rubber) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK
Penicillin or other antibiotics <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Iodine <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK
Barbiturates, sedatives, or sleeping pills <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Hay fever/seasonal <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK
Sulfa drugs <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Animals <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK
Codeine or other narcotics <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Food <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK
	Other <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

Artificial (prosthetic) heart valve <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Autoimmune disease <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK
Previous infective endocarditis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Rheumatoid arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Hepatitis, jaundice or liver disease <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK
Damaged valves in transplanted heart <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Systemic lupus erythematosus <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Epilepsy <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK
Congenital heart disease (CHD)	Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Fainting spells or seizures <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK
Unrepaired, cyanotic CHD <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Bronchitis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Neurological disorders <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK If yes, specify: _____
Repaired (completely) in last 6 months <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Sleep disorder <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK
Repaired CHD with residual defects <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Sinus trouble <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Do you snore? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK
<i>Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.</i>	Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Mental health disorders <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Specify: _____
	Cancer/Chemotherapy/ Radiation Treatment <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Recurrent Infections <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Type of infection: _____
Cardiovascular disease <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Chest pain upon exertion <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Kidney problems <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK
Angina <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Chronic pain <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Night sweats <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK
Arteriosclerosis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Diabetes Type I or II <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Osteoporosis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK
Congestive heart failure <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Eating disorder <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Persistent swollen glands in neck <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK
Damaged heart valves <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Malnutrition <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Severe headaches/migraines <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK
Heart attack <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Gastrointestinal disease <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Severe or rapid weight loss <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK
Heart murmur <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	G.E. Reflux/persistent heartburn <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Sexually transmitted disease <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK
Low blood pressure <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Excessive urination <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK
High blood pressure <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Thyroid problems <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	
Other congenital heart defects <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK		
Name of physician or dentist making recommendation: _____	Phone: <i>Include area code</i> () _____	
Do you have any disease, condition, or problem not listed above that you think I should know about? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Please explain: _____		

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: _____ Date: _____

Signature of Dentist: _____ Date: _____

FOR COMPLETION BY DENTIST

Comments: _____



Welcome!

Thank you for choosing Mankame, Dipak M., D.D.S., P.A. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- ✓ American Express, Debit, Cash, Discover, Visa, MasterCard, Check, Discover Card or Zelle (954-682-4682).
- ✓ A transaction fee of 2.5% will be applied to all major credit card payments for treatments that exceed \$3000.
- ✓ Convenient Monthly Payment Options from *Care Credit (Healthcare Credit Card), and Cherry*
 - Allow you to pay overtime and no annual fees or pre-payments penalties.

Please Note:

Payment is required prior to the completion of your treatment. Should you choose to discontinue care before treatment is fully completed, a refund will be issued minus the cost of the care received.

For extensive treatments, we offer a payment plan divided into three installments: an initial payment, a mid-treatment payment, and a final payment. All payments are to be made prior to the commencement of treatment on the day of your appointment. A deposit is necessary to secure your initial appointment for procedures such as bridges, crowns, dentures, implants, orthodontics, and surgeries. This deposit will be applied to the overall treatment cost.

For patients possessing dental insurance, we are pleased to work with your insurance provider to maximize your benefits and will directly submit claims for reimbursement regarding your treatment.

Please be advised that a fee ranging from \$50 to \$150 will be applied to patients who miss or cancel appointments more than once within a calendar year without providing 24-hour notice (please refer to our cancellation policy). Additionally, Mankame Dipak, DDS, PA imposes a charge of \$75 for returned checks.

Should you have any inquiries, please feel free to ask. We are committed to assisting you in obtaining the dental care that you desire and require.

Signature of Patient or Authorized Representative _____ Date: _____

CONSENT FOR TREATMENT

I hereby certify that I have read and understand. I grant permission to Dr. Disha, Gauri Mankame, DMD, as well as their associates and staff, to administer any medications and procedures they consider necessary for the maintenance of my oral and dental health, or that of my child or legal ward. This includes the administration of local anesthetics and other medically indicated pharmaceuticals deemed necessary in their professional judgment.

Furthermore, I authorize the execution of any operative and technical procedures essential for completing a diagnosis and implementing the recommended treatment.

I also consent to the acquisition and use of any part of my records, photographs, videos, or films that may be required for examination, diagnosis, and treatment.

Signature of patient or Authorized Representative _____ Date: _____

*3rd party financing and is subject to credit approval. **



Cancellation and Missed Appointment Policy

Our goal is to provide quality individualized holistic health care. We would like to remind you of our office policy regarding late cancellations or missed appointments.

Cancellation of an Appointment

In order to offer quality care with individualized attention, we reserve a full hour or more for treatments. "No-Shows" and late cancellations inconvenience those seeking our care. We therefore ask for 48hour/24hour notice prior to your scheduled appointment if you must cancel or reschedule an appointment. Appointments are in high demand and your early cancellation will give another person the possibility to have access to timely care. You have the options to:

1. **Call** the office promptly at 954-791-1630,
2. **Leave a message** on our voicemail (if no answer/afterhours),
3. **Text us back** at the text message reminder or
4. **Email** us at Plantationsmilecare@gmail.com

If an appointment is not cancelled at least 48 hours in advance you may be charged a cancellation fee!

First cancelled/missed appointment without advance notice:

We do understand unforeseen situation happens. As a courtesy, we **may** waive the **first** cancellation/missed appointment. However, that appointment must be reschedule with 30 days.

Second cancellation/missed appointment without (48 hours) advance notice:

you'll may be required to **prepay in full** for future treatment and any outstanding to secure another appointment, requiring a credit card on file.

Third cancellation/missed appointment without (48 hours) advance notice:

Third missed appointment may result in *Full visit fee, depending on Dentist or visit and/ or dismissal from the practice.

Cancellation/missed appointment fees:

Less than 48 hours: \$50 (Hygiene appointments)

Less than 24 hours: \$100/\$150/\$200 (*Full visit fee, depending on Dentist or visit type).

By Signing this payment agreement & cancellation policy you are indicating that you understand and agree to the terms of service explained above.

Name of Patient: _____

Signature: _____ Date: _____

Witness Signature: _____