

Health History Form



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 of person completing form and relationship to patient

Name

Relationship

Do you have any of the following diseases or problems:

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

Yes No DK

- Active Tuberculosis.....
- Persistent cough greater than a 3 week duration.....
- Cough that produces blood.....
- Been exposed to anyone with tuberculosis.....

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Dental Information

For the following questions, please mark (X) your responses to the following questions.

	Yes	No	DK		Yes	No	DK
Do your gums bleed when you brush or floss?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have earaches or neck pains?	<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"/>
Does food or floss catch between your teeth?	<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"/>
Is your mouth dry?.....	<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 had any periodontal (gum) treatments?	<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 ever had orthodontic (braces) 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"/>
Have you had any problems associated with previous dental treatment?.....	<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"/>
Is your home water supply fluoridated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Date of your last dental exam:			
Do you drink bottled or filtered water?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	What was done at that time?			
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY				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.

	Yes	No	DK		Yes	No	DK
Are you now under the care of a physician?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you had a serious illness, operation or been hospitalized in the past 5 years?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physician Name: _____				If yes, what was the illness or problem?			
Phone: <i>Include area code</i> () _____				Are you taking or have you recently taken any prescription or over the counter medicine(s)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Address/City/State/Zip: _____				If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements:			
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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____			
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)			Yes No DK				Yes No DK				
Do you wear contact lenses?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you use controlled substances (drugs)?.....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you use tobacco (smoking, snuff, chew, bidis)?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Date: _____ If yes, have you had any complications?						If so, how interested are you in stopping? (Circle one) VERY / SOMEWHAT / NOT INTERESTED					
Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you drink alcoholic beverages?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, how much alcohol did you drink in the last 24 hours? _____					
Date Treatment began: _____						If yes, how much do you typically drink in a week? _____					
WOMEN ONLY Are you:											
Pregnant?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Number of weeks: _____					
Taking birth control pills or hormonal replacement?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nursing?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nursing?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
Allergies - Are you allergic to or have you had a reaction to:			Yes No DK				Yes No DK				
To all yes responses, specify type of reaction.						Metals _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Local anesthetics _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Latex (rubber) _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Iodine _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin or other antibiotics _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hay fever/seasonal _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates, sedatives, or sleeping pills _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Animals _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sulfa drugs _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Food _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Codeine or other narcotics _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.											
			Yes No DK				Yes No DK				Yes No DK
Artificial (prosthetic) heart valve			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Autoimmune disease			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Previous infective endocarditis			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid arthritis			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Damaged valves in transplanted heart			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Systemic lupus erythematosus.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Congenital heart disease (CHD)						Asthma			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unrepaired, cyanotic CHD			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Repaired (completely) in last 6 months			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Repaired CHD with residual defects			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus trouble			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						Tuberculosis			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.</i>						Cancer/Chemotherapy/ Radiation Treatment			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			Yes No DK				Yes No DK				Yes No DK
Cardiovascular disease.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain upon exertion			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Angina			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic pain			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arteriosclerosis			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes Type I or II			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Congestive heart failure			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eating disorder			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Damaged heart valves			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Malnutrition			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal disease			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	G.E. Reflux/persistent heartburn			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low blood pressure			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other congenital heart defects			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						Glaucoma			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mitral valve prolapse			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis, jaundice or liver disease			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fainting spells or seizures			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic heart disease			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neurological disorders			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal bleeding			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, specify: _____					
Anemia			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sleep disorder			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood transfusion			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mental health disorders			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, date: _____						Specify: _____					
Hemophilia			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent Infections			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
AIDS or HIV infection			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Type of infection: _____					
Arthritis			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney problems			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						Night sweats			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						Osteoporosis			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						Persistent swollen glands in neck			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						Severe headaches/ migraines			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						Severe or rapid weight loss			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						Sexually transmitted disease			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						Excessive urination			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?											
Name of physician or dentist making recommendation:									Phone:		
Do you have any disease, condition, or problem not listed above that you think I should know about?											
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: _____

FOR COMPLETION BY DENTIST

Comments: _____

Matthes Dental Practice Account Registration Form

PATIENT INFORMATION

Name:		Date of Birth	Social Security #	
Street Address / Apartment #		City	State	Zip
Sex: M F	Home Phone #	Cell Phone #	Email Address	
Emergency Contact Name & Phone #				

IF PATIENT IS MINOR-RESPONSIBLE PARENT OR GUARDIAN

Name:		Date of Birth	Social Security #	
Street Address / Apartment #		City	State	Zip
Email Address			Phone #	

PRIMARY DENTAL INSURANCE:

Subscriber Name		Date of Birth	Social Security #	Relationship to Patient
Subscriber Address		City	State	Zip Code
Insurance Company Name				
Insurance Company Mailing Address				
Subscriber / Member ID #			Group ID #	
Insurance Plan Name (If Known)			Insurance Company Phone #	

SECONDARY DENTAL INSURANCE:

Subscriber Name		Date of Birth	Social Security #	Relationship to Patient
Subscriber Address		City	State	Zip Code
Insurance Company Name				
Insurance Company Mailing Address				
Subscriber / Member ID #			Group ID #	
Insurance Plan Name (If Known)			Insurance Company Phone #	

**Please notify our office should any of the above information change due to change of address or insurance coverage to ensure proper submission of records.*

I authorize release of any information required in the course of examination and / or treatment. I permit payment of insurance benefits to the dentist for services rendered. I recognize and accept responsibility for payment of services not covered by insurance benefits.

Patient / Legal Guardian Signature:

_____ Date: _____

John J Matthes DDS PLLC
Financial Policy

Payments: Payments are due at the time of service unless other arrangements have been made. This includes insurance co-pays, deductibles and treatment not covered by your insurance benefits.

Insurance: Insurance is a contract between you and your insurance company. We will bill your primary and secondary insurance as a courtesy to you. Although we estimate what your insurance company will pay, it is the insurance company that makes the final determination of the amount they will pay. You agree to pay any portion of the charges not covered or paid by insurance. Delays in payment from the insurance company of more than 45 days will result with patient being billed the full amount.

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. Payment is expected on receipt of the statement.

Finance Charge: A finance charge of 1.5% per month (18% per year) will be added to the account for all amounts overdue more than 30 days. The minimum finance charge will be \$5.00.

Returned Checks: There is a fee (currently \$50) for any checks returned by the bank.

Past Due Accounts: If your account becomes past due, we will take the necessary steps to collect this debt. If your account is submitted to a collection agency or to an attorney you agree to pay all reasonable collection and attorney fees. In case of a lawsuit you agree the venue will be in New York, New York.

Waiver of Confidentiality: You understand that if this account is submitted to a collection agency or to an attorney for litigation, the fact that you received specific treatment at our office may become a matter of public record. Your failure to pay in a timely matter constitutes a waiver of confidentiality.

Missed Appointment Fee: If you are scheduled for an appointment and fail to provide 24 hour notice to reschedule or cancel the appointment, we will impose a \$120 fee for the missed appointment. Patients who cancel / miss three (3) appointments will be dismissed from the practice.

Transferring of Records: If you need copies of your records and / or x-rays sent to another provider's office, you must make this request in writing. Our current copying fee (\$.10 per page) must be paid before we will transfer paper records. ELECTRONIC records will be sent at no charge. You authorize us to include all relevant information, including your payment history. If you are requesting your records to be transferred from another provider to us, you authorize us to receive all information sent.

Divorce: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for the child will be the parent responsible to us for the subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Worker's Compensation: If workers compensation is to pay for our services, we require a written approval / authorization by your employer and / or worker's compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for payment in full.

Personal Injury: If you are being treated as part of a personal injury lawsuit or claim, we require verification from your attorney prior to your initial visit. In addition to this verification, we require that you allow us to bill your dental insurance. In the absence of insurance, other financial arrangements may be discussed. Payment of the bill remains the patient's responsibility and is due at the time of service. We cannot bill your attorney.

I HAVE READ AND UNDERSTAND ALL OF THE TERMS
AND CONDITIONS OF THIS AGREEMENT.

Patient's Name _____ Parent or Guardian _____
(If patient is a minor)

Patient Signature _____ Date _____

Witness _____

Informed Consent/HIPAA Patient Name: _____

I hereby authorize Matthes Dental and whoever he/she may designate to perform upon me those dental procedures which we have discussed, and I have accepted in the treatment plan. If any unforeseen condition arises in the course of these designated procedures calling, in their judgment, for procedures in addition to or different from those now contemplated, I further request and authorize whatever he/she deems advisable.

I consent to the treatment plan I have accepted after having been advised of alternate plans of treatment available.

I am informed and fully understand that there could be at any time a student, not employed by Matthes Dental, either job shadowing or observing my treatment (student(s) will not render treatment).

I am informed and fully understand that there are certain risks in any dental treatment. These risks include but are not limited to: post-treatment pressure and temperature sensitivity, pain or throbbing, pulpal inflammation, fracturing of new restorations due to early biting pressures, tenderness of abutment teeth, tenderness of tissues under removable dentures, post-operative pain and throbbing, swelling and re-infection, fracturing of files or the crown portion of the tooth during and following root canal therapy, sensitivity of the teeth and gums during and following dental cleanings. Any of these complications may be temporary or permanent.

I further consent to the administration of any drugs that may be deemed necessary in my case, including, but not limited to: local anesthetics, antibiotics, and analgesics. I understand that there is a slight element of risk inherent in the administration of any drug or anesthesia. These risks include, but are not limited to, the following complications: adverse drug response (e.g. irritation and swelling of a vein), aspiration, pain, discoloration, and injury to blood vessels and nerves which may be caused by injections of any medications or drugs.

A more complete explanation of all complications is available to me from the Doctor upon my request.

I am aware that, in spite of the possible complications and risks, my treatment is necessary and desired by me. I realize that the practice of dentistry is not an exact science, and I acknowledge that no guarantees have been made to me concerning the results of the procedures.

Health Information Privacy Policies & Procedures

I acknowledge that I have been made aware of the Notice of Privacy Practices. I may receive a copy of the Notice of Privacy Practices if I request one. In addition to those described in the Privacy Policy, I give my permission for Matthes Dental to discuss my health care and billing information with the following people:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient Signature: _____ Date: _____

Doctor/Staff Initials: _____

Patient Screening Form

Patient Name:

	PRE-APPOINTMENT	IN-OFFICE
	Date:	Date:
Do you/they have fever or have you/they felt hot or feverish recently (14-21 days)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you/they having shortness of breath or other difficulties breathing?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you/they have a cough?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you/they experienced recent loss of taste or smell?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you/they in contact with any confirmed COVID-19 positive patients? <i>Patients who are well but who have a sick family member at home with COVID-19 should consider postponing elective treatment.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is your/their age over 60?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you/they have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you/they traveled in the past 14 days to any regions affected by COVID-19? (as relevant to your location)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Positive responses to any of these would likely indicate a deeper discussion with the dentist before proceeding with elective dental treatment.

- For testing, see the list of [State and Territorial Health Department Websites](#) for your specific area's information.