

Health History Form

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American Dental Association
www.ada.org

E-mail: _____ 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: Last First Middle	Home Phone: <i>Include area code</i> ()	Business/Cell Phone: <i>Include area code</i> ()
Address: Mailing address	City:	State: Zip:
Occupation:	Height:	Weight: Date of birth: Sex: M F
SS# or Patient ID:	Emergency Contact:	Relationship: Home Phone: () Cell Phone: () <i>Include area codes</i>

If you are completing this form for another person, what is your relationship to that person?

Your Name _____ Relationship _____

Dental Insurance Company / Dental Benefit Plan Information _____ Company/Plan Name, Address, City, State, Zip Code	Dental Insurance Policy Holder Information _____ Name Date of Birth Insurance ID # Social Security #
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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: _____ 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)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you in good health?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements:			
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)?		
Are you taking, or have you taken, any diet drugs such as Pondimin (fenfluramine), Redux (dexphenfluramine) or phen-fen (fenfluramine-phentermine combination)?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you use tobacco (smoking, snuff, chew, bidis)?		
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"/>	If so, how interested are you in stopping? (Circle one) VERY / SOMEWHAT / NOT INTERESTED		
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"/>	Do you drink alcoholic beverages?		
Date Treatment began:						If yes, how much alcohol did you drink in the last 24 hours?		
						If yes, how much do you typically drink in a week?		
						WOMEN ONLY Are you:		
						Pregnant?		
						Number of weeks:		
						Taking birth control pills or hormonal replacement?		
						Nursing?		

Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?

Date: If yes, have you had any complications?

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		
Local anesthetics			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Latex (rubber)		
Aspirin			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Iodine		
Penicillin or other antibiotics			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hay fever/seasonal		
Barbiturates, sedatives, or sleeping pills			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Animals		
Sulfa drugs			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Food		
Codeine or other narcotics			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other		

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

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THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that health providers keep your medical and dental information private. The HIPAA privacy rule states that health providers must also provide patients with a written Notice of Privacy Practices. This notice is dated January 2008. The Privacy Practices described will be in effect after this date and until or if they are replaced. You may obtain additional copies of this Notice upon request.

Uses and Disclosure of Information

Treatment Services

We may use or provide you health information to all of our staff members, other dentists, your physicians, and/or other healthcare providers taking care of you. We may also provide mail, phone or electrical contact as appointment reminders, recommendations of treatment alternatives, information about other health services and/or other office services.

Payment and Operations

We may provide your health information as required to allow for payment for services and participation in quality assurance, disease management, training, licensing, and certification programs.

Marketing

We will not use your health information for marketing purposes without your written consent.

Legal Requirements

We may disclose your health information when required by law.

Threat to Health and Safety

If abuse or neglect is reasonable, we may disclose your health information to the appropriate governmental authorities.

National Security

When required, we may disclose military personnel with health information to the Armed Forces. Information may be given to authorized federal officials when required for intelligence and national security.

Family Members, Friends, and Others Involved in Care

At your request, we may disclose your health information to a family member or other person if necessary to assist with your treatment and/or payment for services. Based on our judgement and as per 164.522(a) of HIPAA we may disclose your information to these persons in the event of an emergency situation. We also may make information available so that another person may pick up filled prescriptions, medical supplies, records, or x-rays for you. Your information may be disclosed to assist in notifying a family member, caregiver, or personal representative of your location or condition.

Patient Rights

You have the right to see your information and receive copies of your records under most circumstances. Your request must be in writing, addressed to the contact officer. You may be charged for the cost of making copies including the actual copies and staff time. Postage will be added if copies are requested to be mailed. A summary of your health information can also be requested for a fee.

You may request a listing of any situations where we or our business associates disclosed your health information for purposes other than treatment, payment, or other activities for the last six years. You may be charged for costs associated with our response.

You may request that we observe additional restrictions on the disclosure of your information. We are not required to agree to these restrictions, but we may do so (except in case of an emergency).

If you believe that changes should be made to your health information, you must request this in writing. You must provide an explanation as to why changes should be made. Even with your request, changes may be refused under certain circumstances.

If you would like to receive your health information in an alternate format or at a specified location you must make your request in writing.

Acknowledgement of Receipt of Notice of Privacy Practices

By signing this form I confirm that I have had the opportunity to receive a copy of the Notice of Privacy Practices.

PRINT NAME _____

SIGN NAME _____ DATE _____

Alan B. Sheiner DDS, FACP
Diplomate American Board of Prosthodontics, 500 East 77th Street, New York, NY 10162
212-249-2211 (O), FAX: 929-226-0622, alansheiner@drsheiner.com

Dear Patient:

In an effort to provide you with quality dental care and flexible payment arrangements, we have expanded our payment policy.

Payment Arrangements are requested at the time of your visit.

We now offer the following payment options:

_____ Payment by cash

_____ Payment by check

_____ Payment by credit card

_____ Guarantee your insurance co-payments with credit card

_____ Automatic billing to your credit card

_____ Payment with CareCredit

Please make a choice, sign below, and return to the doctor before your visit.

Our office is a fully approved and accredited user of the credit card healthcare incentive program, which will enable you to use your credit card to automatically cover amounts not paid by your insurance.

Print your name and sign and date below

Signature

Date