# Health History Form

A	A	
	$\neg$	g

E-mail: Today's Date:

American Dental Association www.ada.org

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:			Home Phone	Include area code	Business/Cell Phone	Include area code
Last	First	Middle	( )		( )	
Address:	11131	iviidale	City:		State:	Zip:
Mailing address						
Occupation:			Height:	Weight:	Date of birth:	Sex: M F
SS# or Patient ID:	Emergency Contact:		Relationship:	Но	me Phone:	Cell Phone:
	2 3 2 3 2 2		,	(	)	( )
If you are completing this form	n for another person, what is you	r rolationship to t	that parcon?		Include area codes	
, ,	Tiol allother person, what is you	r relationship to	illat person?			
Your Name	landa a diagana an anakiana.		Relationship	DK'' D KK		
	lowing diseases or problems:			-	ow the answer to the que	
	a 3 week duration					
	tuberculosis					
If you answer yes to any of	f the 4 items above, please sto	p and return th	is form to the	receptionist.		
Dental Informa	tion For the following questi	ons, please mark	(X) your respon	nses to the followi	ng questions.	
	3 /	Yes No DK			3 /	Yes No Di
Do your gums bleed when you	u brush or floss?	🗆 🗆 🗆	Do you have	earaches or neck r	pains?	
	d, hot, sweets or pressure?		-		ing or discomfort in the	
•	een your teeth?				า?	
			-		our mouth?	
	(gum) treatments?				ls?	
	c (braces) treatment?				reational activities?	
Have you had any problems asso			1 1		ury to your head or mou	
treatment?		🗆 🗆 🗆	-	last dental exam:		
	oridated?			one at that time?		
	d water?		vviiat vvas uc	nie at that time:		
If yes, how often? Circle one: [	DAILY / WEEKLY / OCCASIONALLY		Date of last of	Hental v-rays:		
Are you currently experiencing	dental pain or discomfort?	🗆 🗆 🗆	Date of last e	icitai x rays.		
What is the reason for your de	ental visit today?					
How do you feel about your sr	mile?					
Medical Inform	nation Please mark (X) your	resnonse to indic	ate if you have	or have not had a	any of the following dise:	ases or problems
	G CT G TT Trease Thank (by your	Yes No DK	die II you nave	or nave not nad a	iny or the following discu	Yes No Di
Are you now under the care of	f a physician?		Have you had	d a serious illness, o	operation or been	ies No Di
Physician Name:		clude area code			?	
y siciai tai.i.e.	( )	crade area esae	· ·	was the illness or p		
Address/City/State/Zip:			- If yes, write v	vas trie iliriess or p	TOBICITI:	
Address/City/State/Zip.						
Ann					ently taken any prescripti	
_		🗆 🗆 🗆			?	
Has there been any change in yo					tamins, natural or herbal	preparations
		ப ப ப	and/or diet si	appiernents.		
If yes, what condition is being	treated?					
Date of last physical exam:			1			

#### 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 Do you wear contact lenses? ..... Do you use controlled substances (drugs)?..... Do you use tobacco (smoking, snuff, chew, bidis)?..... Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? ...... If so, how interested are you in stopping? Date: \_\_\_\_\_\_ If yes, have you had any complications?\_\_\_\_\_ (Circle one) VERY / SOMEWHAT / NOT INTERESTED Are you taking or scheduled to begin taking either of the Do you drink alcoholic beverages?..... If yes, how much alcohol did you drink in the last 24 hours?\_\_\_\_\_ medications, alendronate (Fosamax®) or risedronate (Actonel®) If yes, how much do you typically drink In a week? \_\_\_\_\_ for osteoporosis or Paget's disease? ..... Since 2001, were you treated or are you presently scheduled WOMEN ONLY Are you: to begin treatment with the intravenous bisphosphonates Pregnant? ...... (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal Number of weeks: complications resulting from Paget's disease, multiple myeloma Taking birth control pills or hormonal replacement?...... or metastatic cancer?...... Nursing?..... Date Treatment began: \_\_\_ **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\_\_\_ Latex (rubber) Aspirin Iodine Penicillin or other antibiotics\_\_\_\_\_ Hay fever/seasonal \_\_\_\_\_ Animals\_\_\_\_\_ Food \_\_\_\_\_ Sulfa drugs Codeine or other narcotics \_\_\_\_\_ Other \_\_\_\_\_ 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 ..... Previous infective endocarditis ...... Rheumatoid arthritis ...... $\square$ $\square$ $\square$ liver disease ...... Damaged valves in transplanted heart ...... Systemic lupus erythematosus. Epilepsy ...... Congenital heart disease (CHD) Asthma..... П Fainting spells or seizures...... $\square$ ngenital neart disease (CHD) Unrepaired, cyanotic CHD...... Neurological disorders...... Bronchitis..... Repaired (completely) in last 6 months ...... Emphysema ...... If yes, specify:\_\_\_\_\_ Sleep disorder...... Repaired CHD with residual defects ...... Sinus trouble..... Mental health disorders ....... Tuberculosis ...... Except for the conditions listed above, antibiotic prophylaxis is no longer recommended Cancer/Chemotherapy/ Specify:\_\_\_ for any other form of CHD. Recurrent Infections ...... Radiation Treatment ......... Yes No DK Chest pain upon exertion ...... Yes No DK Type of infection:\_\_\_\_\_ Chronic pain ...... Kidney problems..... Night sweats..... Diabetes Type I or II...... □ □ Eating disorder..... Osteoporosis...... Persistent swollen glands Congestive heart failure ...... Rheumatic heart disease...... Malnutrition...... Gastrointestinal disease...... Severe headaches/ G.E. Reflux/persistent Heart murmur ...... Blood transfusion ...... heartburn ...... migraines ...... Low blood pressure...... If yes, date:\_\_\_\_\_ Ulcers ..... Severe or rapid weight loss ..... $\square$ $\square$ Sexually transmitted disease .... $\square$ $\square$ $\square$ Thyroid problems ...... П Other congenital heart AIDS or HIV infection ...... Stroke...... Excessive urination...... defects ...... Glaucoma ...... Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ...... Phone: Name of physician or dentist making recommendation: 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:\_\_\_\_



### **Appointment Cancellation Policy**

At Rickoff Dentistry, we have implemented an appointment reminder and confirmation system that utilizes emails and cell phone text messages, as well as personal phone calls, to remind you and your family members of upcoming appointments with our office. It is our pleasure to provide these services to our patients at NO CHARGE as a means to better enhance your patient experience.

If you are ever unable to keep a scheduled appointment with our dental office, we require at least a two (2) business day notice by calling our office to reschedule or cancel your appointment. If your notice is not received within the two (2) business day window, a small, short-notice fee of \$25.00 may be charged to your account.

#### **Patient Financial Responsibility**

As a condition of your treatment by this office, I understand that payment in full is due at the time services are rendered. I may pay with cash, personal check, credit or debit card, or CareCredit. I understand that all emergency dental services or any service performed after regular business hours must be paid at the time services are rendered.

A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all delinquent accounts, starting on the date the debt was incurred.

I consent and understand that any fee estimate or insurance estimate given to me as part of my treatment plan fees is only an estimate, and due to the nature of dental care and the unforeseen problems or changes that may arise during treatment, fees and/or treatment may also change as a result.

In the event that my account becomes delinquent, I understand that future treatment may be delayed until the balance has been paid. I also understand that if my account becomes delinquent, I shall be solely responsible for any and all collection fees, attorney fees, court costs, interest charges, and any other reasonable fee or charge as a result of my delinquent account.

If I choose Assignment of Benefits with regards to my insurance plan reimbursements, I authorize payment of dental benefits, otherwise payable to me, directly paid to Rickoff Dentistry. I also grant my permission to you or your assignee, to telephone me at home or work to discuss matters related to this form. I have read the above conditions of treatment and payment and agree to their content.

	/
Signature of Patient	Date
Printed Name	



## **Acknowledgement of Receipt of HIPAA Notice & Privacy Practices**

	_, hereby acknowledge that I have received and reviewed a
copy of Rickoff Dentistry's HIPAA Notice of Privacy	Practices.
	of Privacy Practices may change periodically and that I an ed HIPAA Notice of Privacy Practices upon request.
understand that, if I have questions about Rick contact the privacy official at Rickoff Dentistry.	coff Dentistry's HIPAA Notice of Privacy Practices, I may
I understand that it is my right to refuse to sign the Dentistry will not refuse treatment to me if I refuse to	nis Acknowledgement should I so choose, and that Rickof o sign this Acknowledgement.
I further understand that I may contact the Secreta should I have concerns regarding Rickoff Dentistry's	ary of the U.S. Department of Health and Human Services privacy policies and procedures.
	1 1
Signature of Patient	Date Date
Signature of Responsible Party	Date
Printed Name of Responsible Party	Relationship



#### **HIPAA Information Communication Release**

The HIPAA privacy law dictates that we are only authorized to communicate with patients themselves, guardians, insurance providers and patients' physicians, unless we have authorization in writing by the patient to communicate with others on their behalf. Please provide all family members or friends you want us to be able to speak with. Spouses are not automatically included, their names must be explicitly stated below. You may opt out by checking "DO NOT RELEASE INFORMATION" box below.

I give the following named person(s) authorization to take messages or speak with the office of Rickoff Dentistry on my behalf, regarding (please check all items authorized). Please note that information will be shared with these parties on a strictly "as needed" basis.

NAME OF AUTHORIZED PERSON(S):					
Relationship:	Phone Numb	per:			
Able to Discuss (circle all that	t apply):				
Appointments: Y   N	Financial: Y   N	Dental Treatment: Y   N			
Insurance: Y   N	Medical History: Y   N	Other:			
NAME OF AUTHORIZED PE	RSON(S):				
	onship: Phone Number:				
Able to Discuss (circle all that					
Appointments: Y   N	Financial: Y   N	Dental Treatment: Y   N			
Insurance: Y   N	Medical History: Y   N	Other:			
DO NOT RELEASE INFORM	ATION TO ANYONE: (In	itial)			
signature below, I acknowled above parameters will rema	ge and understand that this information	ease any health care information. With my on will be kept in my medical record and the writing. It is my responsibility to notify my listed above.			
Patient's Name:		Date:			
Signature of Patient or Author	orized Representative:				