



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

<b>(Check DK if you Don't Know the answer to the question)</b>			<b>Yes No DK</b>				<b>Yes No DK</b>				
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"/>
<b>Joint Replacement.</b> 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? _____					
<b>Allergies</b> - Are you allergic to or have you had a reaction to: To all <b>yes</b> responses, specify type of reaction.			<b>Yes</b>	<b>No</b>	<b>DK</b>				<b>Yes</b>	<b>No</b>	<b>DK</b>
Local anesthetics _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Metals _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Latex (rubber) _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin or other antibiotics _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Iodine _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates, sedatives, or sleeping pills _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hay fever/seasonal _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sulfa drugs _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Animals _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Codeine or other narcotics _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Food _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.</b>											
			<b>Yes</b>	<b>No</b>	<b>DK</b>				<b>Yes</b>	<b>No</b>	<b>DK</b>
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"/>
			<b>Yes</b>	<b>No</b>	<b>DK</b>	Chest pain upon exertion .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular disease. ....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic pain .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Angina .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes Type I or II .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arteriosclerosis .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eating disorder.....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Congestive heart failure .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Malnutrition .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Damaged heart valves.....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal disease.....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	G.E. Reflux/persistent heartburn .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low blood pressure.....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure.....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke.....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other congenital heart defects .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Hepatitis, jaundice or liver disease .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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## 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

I, \_\_\_\_\_, hereby acknowledge that I have received and reviewed a copy of Rickoff Dentistry's HIPAA Notice of Privacy Practices.

I understand that Rickoff Dentistry's HIPAA Notice of Privacy Practices may change periodically and that I am entitled to receive a copy of Rickoff Dentistry's revised HIPAA Notice of Privacy Practices upon request.

I understand that, if I have questions about Rickoff Dentistry's HIPAA Notice of Privacy Practices, I may contact the privacy official at Rickoff Dentistry.

I understand that it is my right to refuse to sign this Acknowledgement should I so choose, and that Rickoff Dentistry will not refuse treatment to me if I refuse to sign this Acknowledgement.

I further understand that I may contact the Secretary of the U.S. Department of Health and Human Services should I have concerns regarding Rickoff Dentistry's privacy policies and procedures.

\_\_\_\_\_  
*Signature of Patient* \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Signature of Responsible Party* \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Printed Name of Responsible Party* \_\_\_\_\_  
*Relationship*

\_\_\_\_\_  
*Signature of Staff Member* \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
*Date*



## 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 Number: \_\_\_\_\_

Able to Discuss (circle all that apply):

Appointments: Y | N

Financial: Y | N

Dental Treatment: Y | N

Insurance: Y | N

Medical History: Y | N

Other: \_\_\_\_\_

**NAME OF AUTHORIZED PERSON(S):** \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Able to Discuss (circle all that apply):

Appointments: Y | N

Financial: Y | N

Dental Treatment: Y | N

Insurance: Y | N

Medical History: Y | N

Other: \_\_\_\_\_

**DO NOT RELEASE INFORMATION TO ANYONE:** \_\_\_\_\_ (Initial)

I understand that my express written consent is required to release any health care information. With my signature below, I acknowledge and understand that this information will be kept in my medical record and the above parameters will remain in effect until revoked by me in writing. It is my responsibility to notify my healthcare provider(s) should I wish to change one or more contact listed above.

Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Patient or Authorized Representative: \_\_\_\_\_