Health History Form

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: *Include area code* ( ) | Business/Cell Phone: *Include area code* ( )

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: ( ) *Include area codes*

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

Your 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
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Does food or floss catch between your teeth?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐
Do you drink bottled or filtered water?	☐	☐	☐
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY			
Are you currently experiencing dental pain or discomfort?	☐	☐	☐

	Yes	No	DK
Do you have earaches or neck pains?	☐	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Do you brux or grind your teeth?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Do you participate in active recreational activities?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐

Date of your last dental exam:

What was done at that time?

Date of last dental x-rays:

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
Are you now under the care of a physician?	☐	☐	☐

Physician Name: | Phone: *Include area code* ( )

Address/City/State/Zip:

	Yes	No	DK
Are you in good health?	☐	☐	☐
Has there been any change in your general health within the past year?	☐	☐	☐

If yes, what condition is being treated?

Date of last physical exam:

	Yes	No	DK
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐	☐

If yes, what was the illness or problem?

	Yes	No	DK
Are you taking or have you recently taken any prescription or over the counter medicine(s)?	☐	☐	☐

If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements:

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Form S500

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? ☐ ☐ ☐

Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? ☐ ☐ ☐
Date: ____________ If yes, have you had any complications?____________

Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease? ☐ ☐ ☐

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? ☐ ☐ ☐
Date Treatment began: ____________________________

Yes No DK

Do you use controlled substances (drugs)? ☐ ☐ ☐

Do you use tobacco (smoking, snuff, chew, bidis)? ☐ ☐ ☐
If so, how interested are you in stopping?
(Circle one) VERY / SOMEWHAT / NOT INTERESTED

Do you drink alcoholic beverages? ☐ ☐ ☐
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? ☐ ☐ ☐

Allergies - Are you allergic to or have you had a reaction to: Yes No DK
To all **yes** responses, specify type of reaction.

Item	Yes	No	DK
Local anesthetics____________	☐	☐	☐
Aspirin____________	☐	☐	☐
Penicillin or other antibiotics____________	☐	☐	☐
Barbiturates, sedatives, or sleeping pills ____________	☐	☐	☐
Sulfa drugs ____________	☐	☐	☐
Codeine or other narcotics ____________	☐	☐	☐
Metals____________	☐	☐	☐
Latex (rubber) ____________	☐	☐	☐
Iodine ____________	☐	☐	☐
Hay fever/seasonal ____________	☐	☐	☐
Animals____________	☐	☐	☐
Food ____________	☐	☐	☐
Other ____________	☐	☐	☐

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

Condition	Yes	No	DK
Artificial (prosthetic) heart valve	☐	☐	☐
Previous infective endocarditis	☐	☐	☐
Damaged valves in transplanted heart	☐	☐	☐
Congenital heart disease (CHD)			
Unrepaired, cyanotic CHD	☐	☐	☐
Repaired (completely) in last 6 months	☐	☐	☐
Repaired CHD with residual defects	☐	☐	☐

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

Condition	Yes	No	DK
Cardiovascular disease.	☐	☐	☐
Angina	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Congestive heart failure	☐	☐	☐
Damaged heart valves	☐	☐	☐
Heart attack	☐	☐	☐
Heart murmur	☐	☐	☐
Low blood pressure	☐	☐	☐
High blood pressure	☐	☐	☐
Other congenital heart defects	☐	☐	☐
Mitral valve prolapse	☐	☐	☐
Pacemaker	☐	☐	☐
Rheumatic fever	☐	☐	☐
Rheumatic heart disease	☐	☐	☐
Abnormal bleeding	☐	☐	☐
Anemia	☐	☐	☐
Blood transfusion	☐	☐	☐
If yes, date:____________			
Hemophilia	☐	☐	☐
AIDS or HIV infection	☐	☐	☐
Arthritis	☐	☐	☐
Autoimmune disease	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Systemic lupus erythematosus.	☐	☐	☐
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐
Tuberculosis	☐	☐	☐
Cancer/Chemotherapy/ Radiation Treatment	☐	☐	☐
Chest pain upon exertion	☐	☐	☐
Chronic pain	☐	☐	☐
Diabetes Type I or II	☐	☐	☐
Eating disorder	☐	☐	☐
Malnutrition	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
G.E. Reflux/persistent heartburn	☐	☐	☐
Ulcers	☐	☐	☐
Thyroid problems	☐	☐	☐
Stroke	☐	☐	☐
Glaucoma	☐	☐	☐
Hepatitis, jaundice or liver disease	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Neurological disorders	☐	☐	☐
If yes, specify:____________			
Sleep disorder	☐	☐	☐
Mental health disorders	☐	☐	☐
Specify:____________			
Recurrent Infections	☐	☐	☐
Type of infection:____________			
Kidney problems	☐	☐	☐
Night sweats	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistent swollen glands in neck	☐	☐	☐
Severe headaches/ migraines	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
Excessive urination	☐	☐	☐

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:____
____
____
____

HIPAA

NOTICE OF PRIVACY PRACTICES SUMMARY

This describes how your health data may be used and shared and hoe you can get access to this data.

I. How we may use your health data:
   a) Treatment-We may use or share your health data to give you medical treatment or other types of services.
   b) Payment-We may use or share your health data to bill you or a third party for payment for services provided to you.
   c) Healthcare Operations-We may use and share your health data for our own operations such as quality control, compliance monitoring, outcome evaluation, audit, etc.

II. Disclosures we do not have to give you a chance to agree or object:
   a) To you
   b) As required by federal, state, local law enforcement.
   c) If child abuse or neglect is suspected.
   d) Public health risks for the purpose of preventing and controlling of disease.
   e) Lawsuits and disputes in response to a court or administrative order.
   f) Law enforcement to help officials respond to criminal activities.
   g) Coroners, medical examiners and funeral directors
   h) Organ or tissue donation facilities if you are an organ donor.
   i) To avert a threat to individual or public health and/or safety.

III. Disclosures where we must give you a chance to agree or object:
   a) Patient directories-You can decide what health data you want to be listed in the patient directories.
   b) Persons involved in your care or payment of your care-we may share your health data with a family member or other person that YOU name as being involved with you healthcare.

IV. Your rights for your health data:
   a) Right to inspect your health record and to receive a copy of your health record upon request.
   b) Right to amend information in your health record that may be incomplete or inaccurate.
   c) Right to know to whom we have disclosed your health information.
   d) Right to limit who receives your health information (in accordance with state laws)
   e) Right to a copy of the complete Notice of Privacy Practices.

Notice of Privacy Practices Receipt

I acknowledge that I have received the Notice of Privacy Practices Summary of Eatontown Dental Care.

Signature of Patient or Representative ____

Print Name and Date of Birth ____

Date ___________________________________

PATIENT RESPONSIBILITY FORM

Patient Name: _________________________________ **Date**:______________

We will assist you with your dental insurance. We will submit claims for treatment performed. We will appeal denials, if applicable. We will request pre-authorizations, if applicable, for planned major procedures, in accordance with your insurance company policy. We will ask for your assistance with you insurance company, if applicable. Insurance quotes and pre-authorizations are an estimate only. Although we preauthorize major procedures with your insurance company, this is not a guarantee of payment. Coverage may be different if your deductible has not been met, annual maximum has been met, your insurance company denies our request for authorization or your insurance applies an alternate benefit.

Co-pays: I understand that I am responsible to pay all co-payments, at the time of service. I understand that I am responsible to pay last payment of restorative dental work at the final insert appointment, if applicable.

Deductible: If my insurance company determines that I have not met my deductible, I understand that I will be responsible to pay the deductible at the time of service, if applicable.

I acknowledge that I assume full responsibility for services rendered if my insurance carrier downgrades or does not cover my claim for treatment performed. I understand the terms of this agreement and accept financial responsibility with or without the use of insurance coverage.

Signature of patient or representative: ____________________________ Date: _________

Whom may we thank for referring you?

-Friend/Family member (name/relationship): ________________________________
- Website: ____
-Internet search (circle one)- Google, Yahoo, Yelp, Facebook, Zocdoc, Healthgrades….
-Newspaper/print: ____
- Insurance company: ____
-Patient- (name):____
-Co-worker-(name):____
-Other:____

Eatontown Dental Care, LLC (732)460-9000

SMILE SURVEY

Please circle your answer to the following questions. If your answer is "no" briefly explain why in the space provided.

Question	Answer
HOW WOULD YOU RATE YOUR SMILE(10 being perfect)?	**1 2 3 4 5 6 7 8 9 10**
IS THERE ANY PART OF YOUR SMILE YOU WOULD LIKE TO CHANGE?	**Y N**
ARE YOU SATISFIED WITH THE COLOR OF YOUR TEETH?	**Y N**
DO YOU HAVE GAPS IN YOUR TEETH THAT YOU ARE UNHAPPY WITH?	**Y N**
ARE YOU HAPPY WITH THE ALIGNMENT OF YOUR TEETH?	**Y N**
ARE YOU UNHAPPY WITH THE APPEARANCE OF ANY FILLINGS OR OTHER EXISTING DENTAL WORK?	**Y N**
ARE YOUR TEETH SENSITIVE?	**Y N**
DO YOUR GUMS BLEED WHEN YOU BRUSH YOUR TEETH?	**Y N**
DO YOU GRIND, SQUEEZE OR CLENCH YOUR TEETH TOGETHER?	**Y N**
PATIENT SIGNATURE:_______________________________	**DATE:**______________