PATIENT INFORMATION (CONFIDENTIAL)

NAME_____ DATE_____

FIRST MI LAST

ADDRESS_____ CITY_____ STATE/PROV._____ ZIP/P.C._____

E-MAIL_____CELLPHONE_____HOME PHONE_____

SS#/SIN_____BIRTHDATE_____

CIRCLE APPRORIATE: MINOR SINGLE MARRIED DIVORCED WIDOWED SEPARATED

IF COLLEGE STUDENT, F.T. / P.T., NAME OF SCHOOL_____CITY_____STATE_____

PATIENT'S OR PARENT'S/GUARDIAN'S EMPLOYER_____WORK PHONE_____

BUSINESS ADDRESS_____CITY_____STATE_____ZIP_____

SPOUSE OR PARENT'S/ GUARDIAN'S NAME_____EMPLOYER_____ WORK PHONE_____

WHOM MAY WE THANK FOR REFERRING YOU?_____

PERSON TO CONTACT IN CASE OF AN EMERGENCY_____PHONE_____

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT_____RELATIONSHIP TO PATIENT_____

ADDRESS_____HOME PHONE_____

DRIVER'S LICENSE #_____BIRTHDATE___ _____SS#/SIN_____

EMPLOYER_____WORK PHONE_____

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? (CIRCLE APPRORIATE) YES / NO

INSURANCE INFORMATION

NAME OF INSURED_____RELATIONSHIP TO PATIENT_____

BIRTHDATE_____SS#/SIN_____DATE EMPLOYED_____

NAME OF EMPLOYER_____UNION OR LOCAL #_____WORK PHONE_____

INSURANCE CO._____TEL. #_____GRP #_____POLICY/ I.D #_____

INS. CO. ADDRESS_____CITY_____STATE_____ZIP_____

HOW MUCH IS YOUR DEDUCTIBLE?_____HOW MUCH HAVE YOU USED?_____MAX ANNUAL BENEFIT?_____

DO YOU HAVE ANY ADDITIONAL INSURANCE? (CIRCLE APPRORIATE) YES / NO IF YES, COMPLETE THE FOLLOWING:

NAME OF INSURED_____RELATIONSHIP TO PATIENT_____

BIRTHDATE_____SS#/SIN_____DATE EMPLOYED_____

NAME OF EMPLOYER_____UNION OR LOCAL #_____WORK PHONE_____

INSURANCE CO._____TEL. #_____GRP #_____POLICY/ I.D #_____

INS. CO. ADDRESS_____CITY_____STATE_____ZIP_____

HOW MUCH IS YOUR DEDUCTIBLE?_____HOW MUCH HAVE YOU USED?_____MAX ANNUAL BENEFIT?_____

X_____ _____

SINGATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR PATIENT NUMBER

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:

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?

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:

_____

_____

_____

_____

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:
To all **yes** responses, specify type of reaction.

	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.

	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.

	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	☐	☐	☐

	Yes	No	DK
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	☐	☐	☐

	Yes	No	DK
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:_____

Delba J. Pena, D.D.S., P.C.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT

_____, has received a copy of this office's notice if Privacy Practices.

_____

Please Print Name

_____

Signature

_____

Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ○ **Individual refused to sign the acknowledgement of receipt.**
- ○ **Communications barriers prohibited obtaining the acknowledgement.**
- ○ **An emergency situation prevented us from obtaining acknowledgement.**
- ○ **Other (Please Specify Below)**

_____

_____

_____

Delba J Pena D.D.S., P.C.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: PATIENT GIVING CONSENT.

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Social Security #: _____

Section B: PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.
Notice of Privacy Practices: you have the right to read our Notice of Privacy Practices before you decide to sign this consent. Our Notice provides a description of our treatment, payment activities and healthcare options of the uses and disclosures we may make of your protected health information and of other important matters about your protected health information. A copy of our Notice accompanies this consent. We encourage you to read it carefully and completely before signing this consent.
We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our Privacy Practices, we will issue a revised Notice of Privacy practice, which will contain the changes.
Those changes may apply to any of your protected health information that we maintain.
You may obtain obtain a copy of our our Notice of Privacy practices, including any revisions of our Notice, at anytime by contacting:

Contact Person: Delba J. Pena D.D.S., P.C.
186 Clinton Street Hempstead, NY 11550
Tel (516) 483-8136
Fax (516) 483-8134

Right to revoke: you will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the contact person listed above. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or continue treating you if you revoke this consent.

I, _____have had full opportunity to read and consider the form: I am giving my consent to your Notice of Privacy practices. I understand that by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment.

Signature:_____Date: _____
If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's name: _____

Relationship to the patient: _____

DENTAL TREATMENT CONSENT

Please read and initial the items checked below and read and sign the section at the bottom of this form.

Patient name: _____

1. WORK TO BE DONE

I understand that I am having the fallowing work done: Fillings___ Bridges___ Crowns ___ Extractions___
Impacted teeth removed ___General Anesthesia ___ Root Canals ___others_____

Initials_____

2. DRUGS AND MEDICATIONS

I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting and/or anaphylactic shock (severe allergic reaction).

Initials_____

3. CHANGES IN TREATMENT PLAN

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the dentist to make any/all changes and additions as necessary.

Initials _____

4. REMOVAL OF TEETH

Alternatives to removal have been explained to me (root canal therapy, crowns, periodontal surgery, etc.) and I authorized the dentist to remove the following teeth_____ and any other necessary for reason in paragraph #3. I understand removing teeth does not always remove all the infection, if present and it may be necessary to have further treatment. I understand the risk involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling my teeth, lips, tongue and surrounding tissue (paresthesia) that can last for indefinite period of time (days or months) or fractured jaw. I understand I may need further treatment by specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility.

Initials_____

5. CROWN, BRIDGES AND CAPS

I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they pre kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown; bridge or cap (including shape, fit, size and color) will be before cementation.

Initials_____

6. DENTURES, COMPLETE OR PARTIAL

I realize that full or partial dentures are artificially, constructed of plastic, metal and/or porcelain. The problem of wearing these appliances has been explained to me including looseness, soreness and possible breakage. I realize the final opportunity to make changes in my new dentures (including shape, fit, size, placement and color) will be the teeth in wax try in. I understand that must dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not included on the initial denture fee.

Initials_____

7. ENDODONTIC TREATMENT (ROOT CANAL)

I realize there is no guarantee that root canal treatment will save my tooth and that complications can occur from the treatment (apicoectomy)

Initials_____

8. PERIODONTAL LOSS (TISSUE & BONE)

I understand that I have a serious condition causing gum and bone inflammation loss and that it can lead to the loss of my teeth. The alternative treatment plans have been explained to me, including gum surgery, replacements and/or extractions. I understand that undertaking any dental procedures may have a future adverse effect on my periodontal condition.

Initials_____

I understand that dentistry in not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I have the knowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I have had the opportunity to read this form and questions have been to my satisfaction. I agree to the proposed treatment.

Signature of patient/or patient guardian _____ Date _____