Medical History Form

Date _____

Cell Phone _____

Name _____ Home Phone _____
Last First Middle

Address _____ Business Phone _____
Number, Street

email _____

City _____ State_____ Zip Code _____ Social Security No. _____

Occupation _____ Company Name _____

Date of Birth _____ Sex M☐ F☐ Height _____ Weight _____ Single _____ Married _____ Significant Other _____
Mo Day Yr

Name of Spouse /Significant Other _____ Emergency Number _____

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

Referred by _____ Closest Relative _____ Phone ( )_____

For the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health.

1. Are you in good health? ..... Yes No
2. Has there been any change in your general health within the past year? ..... Yes No
3. My last physical examination was on _____
4. Are you now under the care of a physician? ..... Yes No
   If so, what is the condition being treated? _____
5. The name and address of my physician(s) is _____
   _____
   _____
6. Have you had any serious illness, operation, or been hospitalized in the past 5 years? ..... Yes No
   If so, what was the illness or problem? _____
7. Are you taking any medicine(s) including non-prescription medicine? ..... Yes No
   If so, what medicine(s) are you taking? _____
8. Do you have or have you had any of the following diseases or problems?
   a. Damaged heart valves or artificial heart valves, including heart murmur or rheumatic heart disease .... Yes No
   b. Cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke)..... Yes No
      1. Do you have chest pain upon exertion? ..... Yes No
      2. Are you ever short of breath after mild exercise or when lying down? ..... Yes No
      3. Do your ankles swell? ..... Yes No
      4. Do you have inborn heart defects? ..... Yes No
      5. Do you have a cardiac pacemaker? ..... Yes No
   c. Allergy ..... Yes No
   d. Sinus Trouble ..... Yes No
   e. Asthma or hay fever ..... Yes No
   f. Fainting spells or seizures ..... Yes No
   g. Persistent diarrhea or recent weight loss ..... Yes No
   h. Diabetes ..... Yes No
   i. Hepatitis, jaundice, or liver disease ..... Yes No
   j. AIDS or HIV infection ..... Yes No
   k. Thyroid problems ..... Yes No
   l. Respiratory problems, emphysema, bronchitis, etc. ..... Yes No
   m. Arthritis or painful swollen joints ..... Yes No
   n. Stomach ulcer or hyperacidity ..... Yes No
   o. Kidney Problems ..... Yes No
   p. Tuberculosis ..... Yes No
   q. Persistent cough or cough that produces blood ..... Yes No
   r. Persistent swollen glands in neck ..... Yes No
   s. Low blood pressure ..... Yes No
   t. Sexually transmitted disease ..... Yes No

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u. Epilepsy or other neurological disease ..... Yes No
v. Problems with mental health ..... Yes No
w. Cancer ..... Yes No
x. Problems of the immune system ..... Yes No

9. Have you ever had abnormal bleeding? ..... Yes No
   a. Have you ever required a blood transfusion? ..... Yes No
10. Do you have any blood disorder such as anemia? ..... Yes No
11. Have you ever had any treatment for a tumor or growth? ..... Yes No
12. Are you allergic or have you had an allergic reaction to:
   a. Local anesthetics ..... Yes No
   b. Penicillin or other antibiotics ..... Yes No
   c. Sulfa Drugs ..... Yes No
   d. Barbiturates, sedatives, or sleeping pills ..... Yes No
   e. Aspirin ..... Yes No
   f. Codeine or other narcotics ..... Yes No
   g. Other _____
13. Have you had any serious trouble associated with any previous dental treatment? ..... Yes No
   a. If so, explain _____
   b. Do you have any disease, condition, or problem not listed above that you think I should know about?.. Yes No
   c. If so, explain _____
14. Are you wearing contact lenses? ..... Yes No
15. Are you wearing removable dental appliances? ..... Yes No
16. Do you smoke?..... Yes No

Women

17. Are you pregnant? ..... Yes No
18. Do you have any problem associated with you menstrual period? ..... Yes No
19. Are you nursing? ..... Yes No
20. Are you taking birth control pills? ..... Yes No

Chief Dental Complaint_____

_____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the 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 errors or omissions that I may have made in the completion of this form.

_____
Signature of Patient

For completion by the dentist.

Comments on patient interview concerning medical history: _____

_____

_____

_____

Significant findings from questionnaire or oral interview: _____

_____

_____

_____

Dental management considerations: _____

_____

_____

_____

_____ _____
Date Signature of Dentist

Medical History Update:

Date	Comments	Signature
_____	_____	_____
_____	_____	_____
_____	_____	_____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgement*

I, _____, have received a copy of this office's Notice of 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
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient #: _____ Social Security #: _____

SECTION B: TO THE PATIENT — 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 whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, 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 Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Michael R. Szabatura, DDS, P.C

Telephone: (212) 753-7400 Fax: (212) 753-7402

E-mail: _____

Address: 424 Madison Avenue, New York, NY 10017

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 to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and 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, payment activities and health care operations.

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 Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Include completed Consent in the patient's chart.

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____