Health History Form

ADA American Dental Association®

America's leading advocate for oral health

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:

© 2007 American Dental Association

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.

Local anesthetics ____________ ☐ ☐ ☐
Aspirin ____________ ☐ ☐ ☐
Penicillin or other antibiotics ____________ ☐ ☐ ☐
Barbiturates, sedatives, or sleeping pills ____________ ☐ ☐ ☐
Sulfa drugs ____________ ☐ ☐ ☐
Codeine or other narcotics ____________ ☐ ☐ ☐

Yes No DK
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 ☐ ☐ ☐

Yes No DK
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: ____________

We are pleased you have selected us to provide dental care for you and your family.

Whom may we thank for referring you to our office? ____________________

Patient Information

Date ______ Patient's Name ____________________ Last ____________________ First ____________________ Middle

Address ____________________ Street ______ Unit# ______ City ______ State ______ Zip

Home Ph. # (___) __________ Work Ph. # (___) __________ Cell Ph. # (___) __________ Marital Status ______

Soc. Sec. # ______ - ______ - ______ Drivers Lic. # __________ E-Mail: __________

Birthdate ___ / ___ / ___ Sex M F If patient is a minor, give parent's/guardian's name ____________________

Name of nearest relative not living with you ____________________ Relationship __________

If patient is a full-time student, fill in school name ____________________

School Address ____________________ Ph. # (___) __________

Emergency Contact ____________________ Ph. # (___) __________

Responsible Party Information

Name ____________________ Last ____________________ First ____________________ Middle

Soc. Sec. # ___ - ___ - ___ Birthdate ___ / ___ / ___ Relationship to Patient __________

Residence ____________________ Street ______ Apt# ______ City ______ State ______ Zip

Mailing Address ____________________ Street ______ City ______ State ______ Zip

How long at this address ______ Home Ph.# (___) ______ Work Ph.# (___) ______ Fax# (___) ______

Previous Address (if less than 3 years) ____________________

Employer __________ Occupation __________ No. Years Employed ______

Employer Address ____________________

Spouse's Name ____________________

Soc. Sec. # ___ - ___ - ___ Birthdate ___ / ___ / ___ Work Ph.# (___) ______ Fax# (___) ______

Employer __________ Occupation __________ No. Years Employed ______

Employer Address ____________________

Insurance Information

Insured's Name __________ Insured's SS# __________ Insured's DOB ______ ID# ______

Insurance Company ____________________ Group # __________

Insurance Co. Address ____________________ Ph. # (___) __________

Insured's Employer ____________________ Ph. # (___) __________

Do you have dual coverage? Yes ___ No ___ If yes: **Please complete the following secondary insurance information.**

Insured's Name __________ Insured's SS# __________ Insured's DOB ______ ID# ______

Insurance Company ____________________ Group # __________

Insurance Co. Address ____________________ Ph. # (___) __________

Insured's Employer ____________________ Ph. # (___) __________

CONSENT:

1. The undersigned hereby authorizes doctor to order x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.
2. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of patient) ____________________. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.
3. I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1 - 1/2% finance charge (18% APR) may be added to my account, in addition to any collection charges.
4. I understand that where appropriate, credit bureau reports may be obtained.
5. I understand that it is my responsibility to advise your office of any changes in the information obtained on this form.
6. I authorize the use of my social security number to file my dental claim.

Patient ____________________ Date __________ Witness ____________________

Parent or Responsible Party ____________________ Relationship to Patient __________

FOR OFFICE USE: Reviewed by Dr. __________ Date: __________

MICHELE HARUTUNIAN, D.D.S.

340 Dogwood Avenue Franklin Square, NY 11010 **(516)538-3800**

==

FINANCIAL MENU

We offer a wide range of financial options in order to pay for your dental treatment.

A) **Pay as You Go**
You may choose to pay your obligation for each visit with cash, check or credit card at the visit.

B) **Split Payments**
Total amount of your treatment will be divided in the amount of visits necessary (if more than 3 visits).
Half of the treatment is due at start of dental work, and the second half due by the day of cementation of crowns/ bridges/ veneers.

C) **Payment in Full**
For any treatment over $2000, a prepayment Bookkeeping Courtesy of 3% will be given for direct payment in full by cash or check before or at the first treatment visit.

D) **CareCredit**
Fast on-line approval in a matter of minutes. Offers: No Interest and low monthly payment options, no up-front costs, no prepayment penalties, and no annual fees so you can complete your dental work in no time.

FORMS OF PAYMENT ON BALANCES DUE

- In order to facilitate access to the very best health care possible, you may choose from any of the following: Cash, Visa, MasterCard, American Express, Discover, Personal Checks, CareCredit (see above).

I understand that if I become delinquent on my account (more than 60 days), my account will be turned over to a collection agency, and I will subsequently be reported to the credit bureaus. In case of total default, I promise to pay any collection costs and attorney fees incurred to collect this amount.

- After your dental insurance has paid for dental services rendered to our office, you may have an outstanding balance. This balance may include any deductibles, copayments, denials, and non-covered services. We do our best to estimate what you will owe. For balance owed, we will require a credit card authorization.
  CREDIT CARD: (check one): ☐ Visa, ☐ MasterCard, ☐ Discover, ☐ Amex, ☐ CareCredit

Card #:______________________________ Expiration Date:________________

Card Holder Signature:____

Billing Address:______________________________ State:_______ Zip:__________

I certify that I have read, fully understand, and accept the above financial policy.

Signature: ______________________________ Date:____________________

www.beyourdentist.com

MICHELE M. HARUTUNIAN, D.D.S.
340 Dogwood Avenue Franklin Square, NY 11010 (516) 538-3800

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Full Name: ______________________________ Telephone: ______________ Social Security#: ______________

Address: ______________________________ City: ______________ State: ______________ Zip: __________

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. 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 our office

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 address above. Please understand that revocation of this Consent will not affect any action we took 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: ______________________________