Health History Form

Today's Date:

DOWNINGTOWN FAMILY DENTISTRY
Hal Cohen, DMD

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:

E-mail:

Occupation:

Height:

Weight:

Date of birth:

Sex: M F

SS# or Patient ID:

Marital Status:

Spouse's Name:

Emergency Contact:

Relationship:

Home Phone: *Include area code* ( )

Cell Phone: *Include area code* ( )

Work Phone: *Include area code* ( )

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

Your Name

Relationship

Dental Information *For the following questions, please mark (X) your responses to the following questions.*

Date of your last dental exam:

Date of last dental x-rays:

	Yes	No	DK
Are you currently experiencing dental pain or discomfort?	☐	☐	☐
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?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐	☐

	Yes	No	DK
Have you ever been diagnosed with sleep apnea?	☐	☐	☐
Do you have earaches or neck pains?	☐	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Do you ever grind, clench or brux your teeth?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐

What is the reason for your dental visit today?

What, if anything would you change about your smile?

Have you ever had an adverse reaction during dental treatment, including fainting, allergic reaction or abnormal bleeding?

Have you noticed any shifting in your teeth, or spaces where there previously weren't any?

Any other complaints?

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

Physician Name:

Phone: *Include area code* ( )

Address/City/State/Zip:

	Yes	No	DK
Any serious injury to your head or neck?	☐	☐	☐
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
Do you suffer from any disability?	☐	☐	☐
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:

_____

_____

_____

_____

	Yes	No	DK
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: _____

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

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
Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	☐	☐	☐
Date: _____ If yes, have you had any complications?_____			
Have you ever, or do you now use controlled substances (drugs)?	☐	☐	☐
Do you use tobacco (smoking, snuff, chew, bidis)?	☐	☐	☐

WOMEN ONLY Are you:	Yes	No	DK
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 _____	☐	☐	☐

	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	☐	☐	☐
Mitral valve prolapse	☐	☐	☐

	Yes	No	DK
Pacemaker	☐	☐	☐
Rheumatic fever	☐	☐	☐
Rheumatic heart disease	☐	☐	☐
Abnormal bleeding	☐	☐	☐
Anemia	☐	☐	☐
Blood transfusion	☐	☐	☐
If yes, date:_____			
Hemophilia	☐	☐	☐
AIDS or HIV infection	☐	☐	☐
Arthritis	☐	☐	☐
Autoimmune disease	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐

	Yes	No	DK
Systemic lupus erythematosus.	☐	☐	☐
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐
Tuberculosis	☐	☐	☐
Persistent / bloody cough	☐	☐	☐
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	☐	☐	☐
Tumors or growths	☐	☐	☐

	Yes	No	DK
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	☐	☐	☐

Name of physician or dentist making recommendation: | Phone:

	Yes	No	DK
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:

Permission To Release Health Information

I grant the right to the dentist to release health information obtained from me, and information about my dental treatment to third party payors, and/or other health practitioners.

Signature: | Date:

If other than patient, indicate relationship:

Reviewed by: | Date:

Dentist Notes:

INSURANCE INFORMATION

Please complete the following insurance information.

EMPLOYEE NAME_____

EMPLOYEE
ADDRESS_____

EMPLOYEE
DATE OF BIRTH_____

EMPLOYEE
SOCIAL SECURITY NUMBER_____

EMPLOYER
NAME_____

EMPLOYER
ADDRESS_____

EMPLOYER
TELEPHONE NUMBER_____

INSURANCE CARRIER
NAME_____

INSURANCE CARRIER
ADDRESS_____

INSURANCE CARRIER
TELEPHONE NUMBER_____

INSURANCE PLAN
GROUP NUMBER_____

INSURANCE ID NUMBER_____

HAL L. COHEN, DMD, LLC

PATIENTS WITH DENTAL INSURANCE

Dr. Cohen does not participate with any insurance. As a courtesy to our patients we will submit to your primary and secondary carrier for payment. The accuracy of the dental plan information is the responsibility of the insured party. The insured should call and verify dental benefits prior to the visit. If payment is not received within thirty days of the date of service the insured will be billed. After the thirty day period, we are unable to resubmit dental claims. Upon request, an attending doctor statement can be made available for the insured to submit to their carrier.

A statement will be sent to you after each insurance payment is received. Account balances, co-payments and deductibles will be due at the time of service. We would appreciate having you remain current rather than having your balance accumulate over several visits. Should you have financial problems that may result in delayed payment of your bill, please contact us so that every effort can be made to arrange a mutually acceptable payment plan.

PATIENTS WITHOUT DENTAL INSURANCE

Patients without insurance coverage are requested to pay for services as rendered. We accept Mastercard and Visa.

ADDITIONAL TERMS

Appointments cancelled or missed with less than 24 hours notice will be subject to a cancellation charge. This amount will not exceed the charges for that appointment. Checks returned by your bank are subject to a $35.00 processing charge subject to change. A billing charge of $1.00 will be accessed to accounts over 30 days. Accounts unpaid after 60 days from the date of service may be subject to a finance charge at 1.5% monthly. Billing charges and finance charges will not be removed. If your account is referred for collection, you will be responsible for collection costs.

Emergencies patients will be scheduled according to availability in Dr. Cohen's schedule. Please understand that we may not be able to accommodate your personal schedule. We require that you call for an appointment rather than walk-in to be seen as an emergency.

I HAVE READ THE ABOVE AND UNDERSTAND THE OFFICE AND INSURANCE INFORMATION

_____ _____

SIGNATURE OF PATIENT OR GUARDIAN DATE

HAL L. COHEN, DMD, LLC

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 to 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)

_____
_____
_____

WAIVER FOR AMENDMENTS TO THE NOTICE OF PRIVACY PRACTICES REQUIRED UNDER THE HIPAA ACT OF 1998

Under the new privacy laws, unless we have the signature of the patient, we cannot give personal dental information to anyone other than the patient (unless the patient is a minor under the age of 18). This includes a spouse and/or parents of a patient. The following are some circumstances in which you may allow us to provide your dental information to another family member.

I authorize Dr. Cohen and/or staff to speak with the following individual(s) on my behalf pertaining to my account, appointments, dental records and pending treatment.

NAME_____RELATIONSHIP_____

NAME_____RELATIONSHIP_____

NAME_____RELATIONSHIP_____

NAME_____RELATIONSHIP_____

_____ _____

SIGNATURE OF PATIENT DATE

PATIENT INFORMATION UPDATE DATE_____

PATIENT NAME_____

GUARDIAN NAME_____

PATIENT SOCIAL SECURITY NUMBER_____

GUARDIAN SOCIAL SECURITY NUMBER_____

ADDRESS_____

CITY_____STATE_____ZIP_____

HOME PHONE_____

WORK PHONE_____

CELL PHONE_____

DENTAL INSURANCE – PRIMARY _____
EMPLOYEE INSURANCE ID NUMBER_____
EMPLOYEE SOCIAL SECURITY NUMBER_____
INSURANCE MAILING ADDRESS_____
INSURANCE PHONE NUMBER_____
GROUP NUMBER_____

NAME OF EMPLOYEE_____

INSURED'S EMPLOYER_____

DENTAL INSURANCE – SECONDARY _____
EMPLOYEE INSURANCE ID NUMBER_____
EMPLOYEE SOCIAL SECURITY NUMBER_____
INSURANCE MAILING ADDRESS_____
INSURANCE PHONE NUMBER_____
GROUP NUMBER_____

NAME OF EMPLOYEE_____

INSURED'S EMPLOYER_____