Health History Form

ADA American Dental Association®
America's leading advocate for oral health

Email: 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: *Include area code* ( ) Cell Phone: *Include area code* ( )

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 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?	☐	☐	☐
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 dietary 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 an antiresorptive agent (like Fosamax®, Actonel®, Atelvia, Boniva®, Reclast, Prolia) for osteoporosis or Paget's disease?	☐	☐	☐
Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia®, Zometa®, XGEVA) 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	☐	☐	☐
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	☐	☐	☐
Do you snore?	☐	☐	☐
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: *Include area code*
( )

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:

Signature of Dentist: Date:

FOR COMPLETION BY DENTIST

Comments:

PLYMOUTH VALLEY PERIODONTAL ASSOCIATES
DOMENICO ZITO, D.M.D.
JOEL S. JASPAN, D.D.S.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

PATIENT ACKNOWLEDGEMENT

Our Notice of Privacy Practices Provides Information about how we may use and disclose protected health information about you. You have the right to review our notice and ask questions about our privacy practices. As provided in our office, the terms of our notice may change. If we change our notice you may obtain a revised copy by requesting one in writing.

By signing this form, you acknowledge that you have received (or have been offered to review) our Notice of Privacy Practices.

_____
Name of Patient

_____
Signature of Patient

_____
Date Signed

Family members and/or Friends Authorized to received medical information about the above named patient.

_____ Relationship:_____
_____ Relationship:_____
_____ Relationship:_____
_____ Relationship:_____

Can we leave a message on your answering machine? ____Yes ____No

Can we leave a message on a machine at any of the above authorized family or friends? ____Yes ____No

Can we call your work number? ____Yes ____No
Can we leave a message/voicemail at work? ____Yes ____No

Who may we thank for referring you to our office? _____
_____

Secondary Guarantor Information

Spouse/Parent Name:_____
Spouse/Parent Date of Birth:_____
Spouse/Parent Social Sec.No:_____

Dental Insurance Information

PRIMARY INSURANCE

Subscriber's Name_____
Subscriber's SS#:_____
Subscriber's DOB:_____
Insurance Alternate I.D. Number (if applicable):_____
Employer's Name:_____
Employer's Address:_____
Phone Number:_____
Insurance Company:_____
Group Number:_____
Claim Mailing Address:_____

SECONDARY INSURANCE

Subscriber's Name_____
Subscriber's SS#:_____
Subscriber's DOB:_____
Insurance Alternate I.D. Number (if applicable):_____
Employer's Name:_____
Employer's Address:_____
Phone Number:_____
Insurance Company:_____
Group Number:_____
Claim Mailing Address:_____

I have completed the above questions to the best of my ability. If the information is incomplete, I do realize I will pay for my dental visits and submit for reimbursement from my insurance myself. I assume responsibility for fees associated with procedures performed regardless of dental coverage in effect. As a courtesy, Plymouth Valley Periodontal Associates will submit charges to my insurance company on my behalf; however, if no payment is received within 60 days, the balance becomes my responsibility. I understand all copays and deductibles are due the day the service is rendered.

SIGNATURE OF PATIENT OR GUARDIAN IF A MINOR DATE

CONSENT FOR LOCAL ANESTHETIC INJECTIONS

I _____, hereby authorize **Domenico Zito, D.M.D./Joel S. Jaspan, D.D.S.** to perform a local anesthetic injection(s).

I understand, and it has been explained to me, that there are some risks in the administration of local anesthetics. Most risks are related to the position or the nerves under the tissue at the site of the injection which cannot be determined prior to the administration of the anesthetic agent. Although the risks seldom occur, they might include the loss of, or disturbed sensation of the tongue and lip on the side of the injection. If this occurs, it is often temporary, and normal sensation usually returns in several days. However, in very rare cases the loss of sensation may extend for a longer period and may become permanent. In addition, injecting a foreign substance into the body such as an anesthetic agent may result in an allergic reaction. Allergic reactions to these agents are rare, but may take place.

I further understand that individual reaction to treatment cannot be predicted, and that if I experience any unanticipated reactions following the injection(s), I agree to report them to the office as soon as possible.

I have been told that the success of my dental treatment depends upon my cooperation in keeping scheduled appointments, following home care instruction, including oral hygiene and dietary instructions, taking prescribed medication and reporting to the office any change in my health status.

I acknowledge that no guarantees or assurances have been given by anyone as to the results that may be obtained.

I have discussed all of the above with the doctor, and have had all my questions answered.

_____	_____
Patient's Signature	If a minor, Signature of Parent or Guardian
_____	_____
Witness Signature	Joel S. Jaspan, D.D.S.
_____	_____
Date	Domenico Zito, D.M.D.

PATIENT RESPONSIBILITY AGREEMENT

I understand and agree that I will be financially responsible for the patient services provided by the Plymouth Valley Periodontal Associates ("also called the Dental Office"), according to the policies stated in this Patient Responsibility Agreement.

PATIENT INFORMATION: The patient information provided to the Dental Office is true and correct. I will notify the Dental Office about any significant future revisions to the patient information furnished.

INSURANCE: If I expect my insurer to cover some or all of the cost of the patient services, the Dental Office will assist me, as a courtesy, in obtaining the appropriate benefits from the insurer by billing the insurer. I agree to cooperate and provide all information necessary to the Dental Office. However, I have the primary relationship with my insurer and the Dental Office is not responsible for guaranteeing that benefits will be received in the amounts and in the time-frame as requested. **I am responsible to resolve any problems with my insurer.** I may request that the Dental Office obtain a pre-estimate of insurance benefits before patient services are performed.

PAYMENT SCHEDULE: Unless my treatment is scheduled over a period of time, and unless I specifically request, and the Dental Office approves in advance, a payment schedule for the patient services, **all payments for services are due when a billing statement is presented after the services are performed.** The Dental Office will not otherwise approved any deferred payment schedule.

BILLING STATEMENT: It is possible that portions of the bill for patient services, such as co-payments, deductibles and exclusions, may not be paid by the insurer. Those unpaid portions must be paid by me when a billing statement is presented after the patient services are performed. Payments may be made in cash, check, or by credit card. If my insurer has not paid the benefits to the Dental Office within 90 days after submission, the Dental Office may then require me to pay for the patient services in full, and any insurance benefits later received by the Dental Office will be returned to me.

REFERRAL FOR COLLECTION: If my account is referred to an outside agency or attorney for collection after 90 days, I will also be responsible for actual collection costs incurred, including all attorney's fees and court costs. The Dental Office may deny subsequent patient treatment if my account balance remains unpaid.

ACCOUNT CHARGES: If my account remains unpaid after 90 days, I can be assessed with additional account charges at the rate of 1.5% per month (18% annually).

ACCOUNT ADJUSTMENT: If I fail to make a co-payment by the date required by my insurer, if applicable, then my account can be adjusted and I would be responsible for the full amount due for the patient services rendered.

FAMILY REPONSIBILITY: I am authorized to agree, for myself and on behalf of my spouse (if applicable), to remain financially responsible for all future services rendered to all of my family members, regardless of ages, unless I notify the Dental Office in writing otherwise.

COLLECTION FROM OTHERS: If I am financially indigent and unable to pay for patient services rendered, the dental office may seek to recover my account balance from certain of my adult relatives under applicable Pennsylvania law.

CANCELLED APPOINTMENT: If an office appointment is canceled with less than 24 hours notice, I can be assessed with a cancellation charge of $35.00.

RETURNED CHECKS: If my check is returned by the bank, I can be assessed with a processing charge of $30.00.

_____ _____

Date Patient or Responsible Party Signature