

Medical Alert:	Condition:	Premedication:	Allergies:	Anesthesia:	Date:
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HEALTH HISTORY FORM

Name: _____ Home Phone: () _____ Business Phone: () _____

Address: _____ City: _____ State: _____ Zip Code: _____
LAST FIRST MIDDLE P.O. BOX or Mailing Address

Occupation: _____ Height: _____ Weight: _____ Date of Birth: _____ Sex: M F

SS#: _____ Emergency Contact: _____ Relationship: _____ Phone: () _____

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

Your email address: _____ Your cell phone: () _____

For the following questions, please (X) whichever applies, your answers are for our records only and will be kept confidential in accordance with applicable laws. 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. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

DENTAL INFORMATION

	Yes	No	Don't Know	
Do your gums bleed when you brush?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	How would you describe your current dental problem? _____
Have you ever had orthodontic (braces) treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Are your teeth sensitive to cold, hot, sweets or pressure?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Date of your last dental exam: _____
Do you have earaches or neck pains?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Date of last dental x-rays: _____
Have you had any periodontal (gum) treatments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	What was done at that time? _____
Do you wear removable dental appliances?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	How do you feel about the appearance of your teeth? _____
Have you had a serious/difficult problem associated with any previous dental treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
If yes, explain: _____				

MEDICAL INFORMATION

	Yes	No	Don't Know																																																													
<p>If you answer yes to any of the 3 items below, please stop and return this form to the receptionist.</p>																																																																
<p>Have you had any of the following diseases or problems?</p>																																																																
Active Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<table border="0"> <thead> <tr> <th></th> <th>Yes</th> <th>No</th> <th>Don't Know</th> </tr> </thead> <tbody> <tr> <td>Are you taking or have you recently taken any medicine(s) including non-prescription medicine?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>If yes, what medicine(s) are you taking? Prescribed: _____</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Over the counter: _____</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Vitamins, natural or herbal preparations and/or diet supplements: _____</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Are you taking, or have you taken, any diet drugs such as Pondimin (fenfluramine), Redux (dexphenfluramine) or phen-fen (fenfluramine-phentermine combination)?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Do you drink alcoholic beverages?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>If yes, how much alcohol did you drink in the last 24 hours? In the past week?</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Are you alcohol and/or drug dependent?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>If yes, have you received treatment? (circle one) Yes / No</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Do you use drugs or other substances for recreational purposes?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>If yes, please list: Frequency of use (daily, weekly, etc.): Number of years of recreational drug use:</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Do you use tobacco (smoking, snuff, chew)?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>If yes, how interested are you in stopping? (circle one) Very / Somewhat / Not interested</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Do you wear contact lenses?</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </tbody> </table>		Yes	No	Don't Know	Are you taking or have you recently taken any medicine(s) including non-prescription medicine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, what medicine(s) are you taking? Prescribed: _____				Over the counter: _____				Vitamins, natural or herbal preparations and/or diet supplements: _____				Are you taking, or have you taken, any diet drugs such as Pondimin (fenfluramine), Redux (dexphenfluramine) or phen-fen (fenfluramine-phentermine combination)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you drink alcoholic beverages?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, how much alcohol did you drink in the last 24 hours? In the past week?				Are you alcohol and/or drug dependent?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, have you received treatment? (circle one) Yes / No				Do you use drugs or other substances for recreational purposes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, please list: Frequency of use (daily, weekly, etc.): Number of years of recreational drug use:				Do you use tobacco (smoking, snuff, chew)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, how interested are you in stopping? (circle one) Very / Somewhat / Not interested				Do you wear contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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	Yes	No	Don't Know
Are you allergic to or have you had a reaction to?			
Local anesthetics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin or other antibiotics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates, sedatives, or sleeping pills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sulfa drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Codeine or other narcotics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Latex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Iodine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hay fever/seasonal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Animals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Food (specify) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Metals (specify) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

To yes responses, specify type of reaction.

Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?

If yes, when was this operation done? _____

If you answered yes to the above question, have you had any complications or difficulties with your prosthetic joint? _____

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?

If yes, what antibiotic and dose? _____

Name of physician or dentist*: _____

Phone: _____

WOMEN ONLY

Are you or could you be pregnant?

Nursing?

Taking birth control pills or hormonal replacement?

Please (X) a response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No	Know
Abnormal bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
AIDS or HIV infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood transfusion. If yes, date: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer/Chemotherapy/Radiation Treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular disease. If yes, specify below:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
___ Angina			
___ Arteriosclerosis			
___ Artificial heart valves			
___ Congenital heart defects			
___ Coronary artery disease			
___ Damaged heart valves			
___ Heart attack			
___ Chest pain upon exertion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
___ Chronic pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
___ Disease, drug, or radiation-induced immunosuppression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
___ Diabetes. If yes, specify below:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
___ Type I (Insulin dependent)			
___ Type II			
___ Dry Mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
___ Eating disorder. If yes, specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
___ Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
___ Fainting spells or seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
___ Gastrointestinal disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
___ G.E. Reflux/persistent heartburn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
___ Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No	Don't Know
Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis, jaundice or liver disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recurrent Infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, indicate type of infection: _____			
Kidney problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental health disorders. If yes, specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Malnutrition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Night sweats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neurological disorders. If yes, specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Persistent swollen glands in neck			
Respiratory problems. If yes, specify below:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
___ Emphysema			
___ Bronchitis, etc.			
Severe headaches/migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Severe or rapid weight loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexually transmitted disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sinus trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sores or ulcers in the mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Systemic lupus erythematosus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Excessive urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any disease, condition, or problem not listed above that you think I should know about? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
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. 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 on patient interview concerning health history:

Significant findings from questionnaire or oral interview:

Dental management considerations:

Health History Update: On a regular basis the patient should be questioned about any medical history changes, date and comments notated, along with signature.

Date	Comments	Signature of patient and dentist
_____	_____	_____

John S. Rizza, D.M.D
7 First Street
North Andover, MA 01845

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: Patient Giving Consent

Name/please PRINT: _____

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, or the uses and disclosures we may make of your protected health information, and of other important matters about 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 the protected health information that we maintain.

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

Contact Person: Kathleen: at 978-685-5804 (Fax# 978-685-7556)

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 of 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 form, I am giving my consent to your use of disclosure of my protected health information to carry our 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 Name: _____

Relationship to Patient: _____

ACKNOWLEDGMENT 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.

Signature: _____

Date: _____

FOR OFFICE USE ONLY

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

1. Individual refused to sign
2. Communications barriers prohibited obtaining the acknowledgement
3. An emergency situation prevented us from obtaining acknowledgement
4. Other (please specify): _____

Informed Consent for General Dental Procedures

You, the patient, have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.

Do not consent to treatment unless and until you discuss potential benefits, risks, and complications with your dentist and all of your questions are answered. By consenting to the treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

It is very important that you provide your dentist with accurate information before, during, and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

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

1. Treatment to be Provided

I understand that during my course of treatment that the following care may be provided:

Examinations _____ Preventative Services _____ Restorations _____
Crowns _____ Bridges _____ Other _____ Patient Initials _____

2. Drugs and Medications

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

4. I give permission to the dental office to bill my dental insurance provider for the treatment provided, if applicable. Patient Initials _____

Patient Signature

Date