

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name: _____

Address: _____

Date of Birth: _____ Date of Request: _____

As required by the Privacy Regulations, this practice may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your authorization.

I hereby authorize this office and any of its employees to use or disclose my Patient Health Information to the following person(s), entity(s), or business associates of this office:

Patient Health Information authorized to be disclosed:

For the specific purpose of (describe in detail)

Effective dates for this authorization: ____/____/____ through ____/____/____

This authorization will expire at the end of the above period.

I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reasons beyond your control.

I understand I have the right to:

1. Revoke this authorization by sending written notice to this office and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this authorization.
2. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.
3. Inspect a copy of the Patient Health Information being used or disclosed under federal law.
4. Refuse to sign this authorization.
5. Receive a copy of this authorization.
6. Restrict what is disclosed with this authorization.

I also understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits whether or not I provide authorization to use or disclose protected Patient Health Information.

Signature of Patient or Patient's Authorized Representative

Date

Authorized Signature of Facility

Date

Dr. Joseph S. Moussa, D.D.S.
1018 Broad Street
Bloomfield, NJ 07003
(973) 338-9191

Name: _____
Last First

Phone#: _____

*What is your chief cosmetic concern?

*What do you hope to achieve with cosmetic dentistry?

*Have you had any cosmetic dentistry performed? When?

*Do you have any fear or apprehension about dentistry?

*Have you been having regular dental treatment in the past?
i.e. Routine cleaning, and exams? When was your last visit?

I understand that Dr. Moussa is performing a clinical exam for cosmetic dentistry and this is not a complete exam for dental caries, dental infections, or gum disease. cursory observations will be noted and appropriate recommendations will be made. A patient may present with certain dental conditions that may not initially allow cosmetic dentistry to be performed until such conditions have been corrected.

I allow Dr. Moussa to perform an individualized cosmetic evaluation for me.

Signature: _____

Date: _____

PATIENT REGISTRATION

Patient's name _____ Birth date _____ Single
Name of spouse/partner _____ Birth date _____ Widowed
If a child, parent's name _____ Married
Street address _____ Phone _____ Divorced
City _____ State _____ Zip _____ Separated
Patient employed by _____ Phone _____ LTP
Business address _____
Present position _____ How long held _____
Spouse/partner employed by _____ Phone _____
Business address _____
Present position _____ How long held _____
Purpose of this appointment _____
In case of emergency, who should be notified _____ Phone _____
Person responsible for this account _____
Social Security number _____
Drivers License number _____
Spouse/partner's Social Security number _____
Spouse/partner's Driver's License number _____
If using Charge Card, name _____ Card no. _____ Exp. date _____
If you have insurance, name of insured (Please bring _____
Name of insurance company _____ Policy no. _____
Is policy connected with a Union Yes No If yes, name of Union _____
Local no. _____ Group no. _____
If spouse/partner has insurance, name of insured _____
Name of insurance company _____ Policy no. _____
Is policy connected with a Union Yes No If yes, name of Union _____
Local no. _____ Group no. _____
Whom may we thank for referring you _____
Your Signature _____ Date _____
Comments: _____

HEALTH QUESTIONNAIRE

Name _____ Birth date _____

Correct answers to the following questions will allow your dentist to treat you on a more individual basis, providing the care appropriate for your particular needs. Circle yes or no, whichever applies, in response to the following questions. Your answers are for our records only and will be considered confidential.

DENTAL

1. Are you having any discomfort at this time Yes No
2. Have you ever had any serious trouble associated with previous dental treatment? Yes No
If so, explain _____
3. Does dental treatment make you nervous? No _____ Slightly _____ Moderately _____ Extremely _____
4. Date of last dental visit _____
5. Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? Yes No
If so, when? _____
6. How often do you brush _____
Brush is: Soft Medium Hard
7. Do you have or have you ever had any of the following?

MOUTH

- | | | |
|--|-----|----|
| Bleeding, sore gums | Yes | No |
| Unpleasant taste/bad breath..... | Yes | No |
| Burning tongue/lips | Yes | No |
| Frequent blisters, lips/mouth..... | Yes | No |
| Swelling/lumps in mouth | Yes | No |
| Ortho treatments (braces)..... | Yes | No |
| Biting cheeks/lips | Yes | No |
| Clicking/popping jaw | Yes | No |
| Difficulty opening or closing jaw..... | Yes | No |

TEETH

- | | | |
|---------------------------|-----|----|
| Loose teeth | Yes | No |
| Sensitive to hot | Yes | No |
| Sensitive to cold..... | Yes | No |
| Sensitive to sweets | Yes | No |
| Sensitive to biting..... | Yes | No |
| Food impaction | Yes | No |
| Clenching/grinding | Yes | No |
| If so, when _____ | | |
| Shifting in bite | Yes | No |
| Change in bite..... | Yes | No |

8. Do you use the following?

Brush	Yes	No
Dental floss.....	Yes	No
Fluoride rinse	Yes	No
Other _____		

MEDICAL

1. Has there been any change in your general health within the past year Yes No
2. My last physical examination was on _____
3. Are you now under the care of a physician..... Yes No
If so, what is the condition being treated _____
4. The name and address of my physician is _____
5. Have you had any serious illness within the past five (5) years Yes No
If so, what was the illness _____
6. Have you been hospitalized or had an operation within the past five (5) years..... Yes No
If so, what was the problem _____
7. Do you have or have you had any of the following diseases or problems

a. Rheumatic fever or rheumatic heart disease	Yes	No
b. Congenital heart disease	Yes	No
c. Cardiovascular disease (heart trouble, heart attack, heart murmur, coronary insufficiency, coronary occlusion, high/low blood pressure, arteriosclerosis, stroke, etc.).....	Yes	No
1) Do you have pain in chest upon exertion.....	Yes	No
2) Are you ever short of breath after mild exercise	Yes	No
3) Do your ankles swell	Yes	No
4) Do you get short of breath when you lie down, or do you require extra pillows when you sleep.....	Yes	No
d. Artificial or replacement valves.....	Yes	No
e. Pacemaker	Yes	No
f. Allergy	Yes	No
g. Sinus trouble	Yes	No
h. Asthma or hay fever	Yes	No
i. Hives or a skin rash.....	Yes	No
j. Fainting spells or seizures.....	Yes	No
k. Diabetes	Yes	No
1) Do you have to urinate (pass water) more than six times a day.....	Yes	No
2) Are you thirsty much of the time	Yes	No
3) Does your mouth frequently become dry.....	Yes	No

- l. Hepatitis, jaundice or liver disease Yes No
m. Arthritis or inflammatory rheumatism Yes No
n. Artificial or replacement joints, prosthetic Yes No
o. Digestive system—Ulcers or stomach disorders (colitis) Yes No
p. Kidney trouble Yes No
q. Tuberculosis Yes No
r. Persistent cough or cough up blood Yes No
s. Immune System disorders (including AIDS, HIV, ARC) Yes No
t. Venereal disease Yes No
u. Other _____ Yes No
8. Have you had abnormal bleeding associated with previous extractions, surgery, or trauma Yes No
a. Do you bruise easily Yes No
b. Have you ever required a blood transfusion Yes No
If so, explain the circumstances & when _____
9. Have you ever tested positive for the AIDS virus Yes No
10. Do you have any blood disorder such as anemia Yes No
11. Have you had surgery or x-ray treatment for a tumor, growth, or other condition Yes No
12. Are you taking any of the following:
a. Antibiotics or sulfa drugs Yes No
b. Anticoagulants (blood thinners) Yes No
c. Medicine for high blood pressure Yes No
d. Cortisone (steroids) Yes No
e. Tranquilizers Yes No
f. Antihistamines Yes No
g. Aspirin Yes No
h. Insulin, tolbutamide (Orinase) or similar drug for diabetes Yes No
i. Digitalis or drugs for heart trouble Yes No
j. Nitroglycerin Yes No
k. Other medications _____ Yes No
l. If "Yes" to any of the above, state drug name, dosage and frequency _____
13. Are you allergic or have you reacted adversely 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. Iodine Yes No
g. Codeine or other narcotics Yes No
h. Other _____ Yes No
14. Do you use any tobacco products Yes No
If so, how much per day and what _____
15. Do you use any alcohol products Yes No
If so, how much per day/week/month and what _____
16. Do you use any caffeinated products (coffee, tea, chocolate, etc.) Yes No
If so, how much per day and what _____
17. Do you have any disease, condition, or problem not listed above that you think I should know about Yes No
If so, explain _____
18. Are you employed in any situation which exposes you regularly to x-rays or other ionizing radiation Yes No
19. Are you wearing contact lenses Yes No
20. Are you experiencing stress or pressure in your work or at home Yes No

WOMEN

21. Are you pregnant Yes No
22. Do you have PMS or problems associated with your menstrual period Yes No
23. Are you taking birth control or hormone therapy Yes No

Remarks:

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health or change in my medication, I will inform the dentist at the next appointment.

Signature of Patient

Date

Signature of Dentist

Date