PATIENT QUESTIONNAIRE

ROBERT A. LEVINE, D.D.S.

Date: _____

Patient name: _____ Sex: M F Birthdate: _____ Age:____

If a dependent, guardian's name: _____

Patient/parent phone at Home: _____ Work: _____

Cell: _____ Do you text message? Yes No Email: _____

Home address: _____
(street) (city) (state) (zip)

Patient/parent employed by: _____

Present position: _____

Name of spouse: _____ Spouse phone: _____

Spouse employed by: _____

Present position: _____

Social Security Number of patient: _____

If patient is a dependent, Social Security Number of parent/guardian: _____

Who will pay for this account? _____

Dental Insurance? If yes, please give us your card to photocopy.

Dental Insurance Subscriber's Name:_____ Birthdate:_____

Social Security #:_____

Second Dental Insurance?
if the patient is covered by a second dental insurance, we need that information before submitting to the first plan.

Second Dental Insurance Subscriber's Name:_____ Birthdate:_____

Social Security #:_____

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

Purpose of your visit: _____

IT IS IMPORTANT TO NOTIFY US IF THERE ARE ANY CHANGES OR UPDATES WITH YOUR HEALTH!

Patient/Parent Signature: _____

MEDICAL HISTORY

ROBERT A. LEVINE, D.D.S.

Date: _____

Patient name: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	Yes	No	_____
Have you ever been hospitalized or had a major operation?	Yes	No	_____
Have you ever had a serious head or neck injury?	Yes	No	_____
Are you taking any medications, pills, or drugs?	Yes	No	_____
Do you use tobacco?	Yes	No	
Do you use controlled substances?	Yes	No	

Females: Are you Pregnant/Trying to get pregnant? Yes No
Nursing? Yes No, Taking oral contraceptives? Yes No

Are you allergic to any of the following?
Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Other _____

Do you have, or have you had, any of the following? (circle where appropriate)

AIDS/HIV Positive	Chest Pains	Frequent Headaches	Irregular Heartbeat	Scarlet Fever
Alzheimer's Disease	Cold Sores/Fever Blisters	Genital Herpes	Kidney Problems	Shingles
Anaphylaxis	Congenital Heart Disorder	Glaucoma	Leukemia	Sickle Cell Disease
Anemia	Convulsions	Hayfever	Liver Disease	Sinus Trouble
Angina	Cortisone Medicine	Heart Attack/Failure	Low Blood Pressure	Spina Bifida
Arthritis/Gout	Diabetes	Heart Murmur	Lung Diesease	Stomach/Intestinal Disease
Artificial Heart Valve	Drug Addiction	Heart Pace Maker	Mitral Valve Prolapse	Stroke
Artificial Joint	Easily Winded	Heart Trouble/Disease	Pain in Jaw Joints	Swelling of Limbs
Asthma	Emphysema	Hemophilia	Parathyroid Disease	Thyroid Disease
Blood Disease	Epilepsy or Seizures	Hepatitis A	Psychiatric Care	Tonsillitis
Blood Transfusion	Excessive Bleeding	Hepatitis B or C	Radiation Treatments	Tuberculosis
Breathing Problem	Excessive Thirst	Herpes	Recent Weight Loss	Tumors or Growths
Bruise Easily	Fainting Spells/Dizziness	High Blood Pressure	Renal/Kidney Dialysis	Ulcers
Cancer	Frequent Cough	Hives or Rash	Rheumatic Fever	Venereal Disease
Chemotherapy	Frequent Diarhea	Hypoglycemia	Rheumatism	Yellow Jaundice

Have you ever had any serious illness not listed above? Yes No

Name and phone number and/or address of Primary Physician? _____

Comments: _____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be detrimental to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____ _____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN REVIEWED BY:

Acknowledgement of Receipt of Statement of Privacy Practices

I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of Robert A. Levine, DDS. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Robert A. Levine, DDS reserves the right to change the privacy practices currently described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed or otherwise transmitted to me.

ADDITIONAL DISCLOSURE AUTHORIZATION		
In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my Protected Healthcare Information to the person(s) identified below. (I understand that the default answer is "NO". Without indicating "YES" in answer to the each individual question, personal protected (PHI) cannot be shared with anyone unless otherwise allowed by HIPAA rules.)		
Spouse only	**☐ YES**	**☐ NO**
OR		
Any Member of my immediate family: (Spouse, Children, Children's Spouses)	**☐ YES**	**☐ NO**
Any Member of my extended family: (Parents, Grandchildren)	**☐ YES**	**☐ NO**
Other: _____	**☐ YES**	**☐ NO**
Name of patient (please print): _____		
Patient signature: _____		
Patient's personal representative: (Please Print): _____		
Personal Representative's signature: _____		
Representative's Telephone Number: _____ **Date:** _____		

OFFICE USE ONLY BELOW THIS LINE

Acknowledgement Not Obtained			
Provided Prior to Treatment?	**☐ YES**	**☐ NO**	**Date Statement Provided:** _____
Reason for not obtaining patient signature	☐	**Needed more time to review Statement**	
	☐	**Wanted to consult another person before signing**	
	☐	**Physically unable to sign**	
	☐	**No reason offered**	
	☐	**Other:**	

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