PATIENT INFORMATION AND HEALTH HISTORY

PERSONAL INFORMATION:

Name:_____ ☐M ☐F Date:_____
Address:_____ City:_____ State:_____ Zip:_____
Home Ph:_____ Work Ph:_____ Cell Ph:_____
Email: _____
Marital Status: ☐ Single ☐ Married ☐Long term partner ☐ Divorced ☐ Separated ☐ Widowed
SS#:_____ DOB:_____ Referred by:_____
Contact in case of emergency:_____ Emergency Ph: _____

WORK INFORMATION:

Employer:_____
Business Address: _____ City:_____ State:_____ Zip:_____

INSURANCE INFORMATION:

Dental Plan:_____ Group #:_____ ID #_____

MEDICAL HISTORY:

Physician's Name:_____ Date of last physical exam:_____
Address:_____ Phone:_____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

☐Allergies to drugs	☐Asthma	☐Immune system disorders (AIDS, HIV)
☐Allergies to anesthetics	☐Hay fever or general allergies	☐ Stroke
☐Latex sensitivity	☐ Diabetes	☐Thyroid
☐Any heart ailments	☐ Kidney problems	☐Tonsillitis
☐High blood pressure	☐ Liver problems or hepatitis	☐Tuberculosis
☐Neurological problems	☐ Malignancies	☐Ulcer or colitis
☐Radiation treatments	☐ Psychiatric care/emotional problems	☐ Chronic fatigue syndrome
☐Bleeding or clotting problems	☐ Rheumatic fever	☐ Pregnancy, if so what month_____
☐Anemia or blood problems	☐ Sinus problems	☐ Any STD's
☐Arthritis	☐ Eye Disorders	☐Other_____

Other Serious Illness:_____
If so, please explain:_____
_____
Medication you are currently taking:_____
Are you taking or have you ever taken Fosomax or Boniva, etc?_____
Are you taking any blood thinners (anticoagulants)?_____

DENTAL HISTORY:

Chief Oral Complaint: _____
Date of last dental exam/cleaning:_____
How often do you visit the dentist: ☐ Never/First time ☐1-2 per year ☐ More than twice a year
Any previous major dental treatment: ☐ YES ☐ NO
If so, for what:_____

DO YOU HAVE OR DO YOU USE ANY OF THE FOLLOWING?

☐Teeth sensitive to cold, heat, sweets, or pressure	☐Unpleasant taste	☐Pain around ear
☐Bleeding gums. How long	☐Unfavorable dental experience	☐Unusual sounds in ear
☐Food impaction	☐Complications from extractions	☐Fluoride supplements
☐Burning of tongue	☐Periodontal treatment	☐Oral habits. i.e., fingernail biting, cheek biting, etc.
☐Swelling or lumps in mouth	☐Orthodontic treatment	☐Cigarettes, pipe or cigar smoking
☐Frequent blisters on lips or mouth	☐Mouth breathing	Type
		Amount_____ Number of years_____

OVER

ORAL HYGIENE:

How many times a day do you brush your teeth?_____
How often do you floss?_____
How often do you change your toothbrush?_____
What type of toothbrush do you use? ☐ Manual ☐ Electric
What is the texture? ☐ Soft ☐ Medium ☐ Hard
Do you brush your tongue?_____ Do you suffer from persistent bad breath (halitosis)?_____
Do you use inter dental stimulators?_____
Do you use a water jet device?_____

COSMETICS:

Are you satisfied with the color of your teeth?	☐ YES ☐ NO
Are you satisfied with the alignment of your teeth?	☐ YES ☐ NO
Are you satisfied with the spacing of your teeth?	☐ YES ☐ NO
Do you notice your gum line receding?	☐ YES ☐ NO
Do you think your teeth look worn or chipped at the edges in the front?	☐ YES ☐ NO
Are there any cosmetic issues you would like to discuss with the Doctor?	☐ YES ☐ NO

Please explain:_____
_____

TEETH GRINDING:

Do you wear a night guard?	☐ YES ☐ NO
Do you have pain in your jaw joints (TMJ)?	☐ YES ☐ NO
Does your jaw joint pop or click?	☐ YES ☐ NO
Do you have difficulty chewing?	☐ YES ☐ NO
Is your jaw sore when you wake up?	☐ YES ☐ NO
Do you clench your teeth?	☐ YES ☐ NO
Do you grind your teeth?	☐ YES ☐ NO

GINGIVA:

Do your gums bleed when you brush?	☐ YES ☐ NO
Do they bleed when you floss?	☐ YES ☐ NO
Have you ever had periodontal surgery?	☐ YES ☐ NO
Have you ever had, or been recommended to have a "deep cleaning"?	☐ YES ☐ NO

APPOINTMENTS: It is our wish that each and every one of our patients receive the very best care and service possible. Once an appointment is made please keep in mind that this time has been reserved for you. If you are unable to make an appointment due to an emergency, please call as soon as possible to let us know so we can reschedule your appointment. With the exceptions of unexpected emergencies we require that you notify us at least 24 hours ahead of time. Failure to give 24-hour notice of a missed appointment will result in a cancellation fee.

INSURANCE: To avoid misunderstandings regarding dental insurance, we wish our patients to know that all professional services rendered are charged directly to the patient, who is personally responsible for payment and fees at the time of service, unless other arrangements have been made. We will prepare necessary insurance forms to help you obtain benefits from your insurance company and accept payment from them. Anything your insurance does not cover, such as your deductible and coinsurance payment, we expect at the time of service.

Signature_____ Date_____

John A. Rubinstein, D.M.D.
Leslie B. Goldfarb, D.D.S.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 04-13-03, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not effect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person=s involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.