DENTAL HISTORY

Reason for today's visit: _____ Last dental visit: _____

Do you have anxiety about dental treatment? Yes / No

Have you ever had complications following dental treatment? Yes / No

If yes, please explain: _____

HEALTH HISTORY

Physician's Name: _____ Date of last physician visit: _____

Address: _____ City: _____ State: _____ Phone: _____

Are you currently under the care of a physician? Yes / No

If yes, please explain: _____

Have you been admitted to a hospital or had emergency care during the past two years? Yes / No

If yes, please explain: _____

Women only: Are you pregnant? Yes / No Due Date: _____ Nursing? Yes / No

Have you ever had any of the following? Please check those that apply:

- ☐ *AIDS/HIV*
- ☐ *Alcohol/Drug Dependency*
- ☐ *Anemia*
- ☐ *Arthritis/ Rheumatism*
- ☐ *Artificial Joints*
- ☐ *Artificial Heart Valves*
- ☐ *Asthma*
- ☐ *Blood Disease/Clots*
- ☐ *Bulimia/ Anorexia*
- ☐ *Cancer, Type*_____
- ☐ *Congenital Heart Defect*
- ☐ *Diabetes*
- ☐ *Dizziness*
- ☐ *Epilepsy/ Seizures*
- ☐ *Excessive Bleeding*
- ☐ *Fainting*
- ☐ *Glaucoma*
- ☐ *Seasonal Allergies*
- ☐ *Head injuries*
- ☐ *Heart Attack*
- ☐ *Heart Disease*
- ☐ *Heart Murmur*
- ☐ *Hepatitis*
- ☐ *Herpes/ Fever Blisters*
- ☐ *High Blood Pressure*
- ☐ *Jaundice*
- ☐ *Kidney Disease*
- ☐ *Leukemia*
- ☐ *Liver Disease*
- ☐ *Mitral Valve Prolapse*
- ☐ *Psychiatric Care*
- ☐ *Pacemaker*
- ☐ *Radiation Treatment*
- ☐ *Respiratory Problems*
- ☐ *Rheumatic or Scarlet Fever*
- ☐ *Sinus Problems*
- ☐ *Stomach Problems*
- ☐ *Swollen Ankles*
- ☐ *Thyroid Disorder*
- ☐ *Tobacco Use*
- ☐ *Tuberculosis*
- ☐ *Ulcers*
- ☐ *Venereal Disease*
- ☐ *Taken FenPhen, Redux,*

Do you have any health problems that need further clarification? Yes / No

If yes, please explain: _____

Please list any medications you are taking: _____

Please list any allergies: _____

Have you ever taken any medications containing bisphosphonates like Fosomax, Actonel, Boniva, Zometa?

Yes / No If yes, please explain: _____

I certify that the above information is accurate and complete to the best of my knowledge. If I ever have any change in my health, I will inform the doctor at the next appointment without fail. I authorize and give consent to perform dental services agreed between Dr. Mitchell Pasenkoff and patient and/or guardian.

Signature_____ Date:_____

MITCHELL S. PASENKOFF DMD

Patient Name:_____ Sex: _____D.O.B _____

Address: _____Marital Status_____

Phone (H): _____ (W):_____C):_____ SS#_____

Insurance Subscriber Name:_____ Is subscriber a patient? Yes / No

Address (if different):_____Phone#_____

Subscriber's D.O.B._____SSN #_____ Subscriber ID _____Group #_____

Insurance Plan Name:_____ Subscriber's Employer:_____

Is patient covered by additional insurance? Yes / No (If yes, secondary form must be completed)

Referred by: _____

Consent for Services

This practice depends on reimbursement from the patient of the incurred costs of their care. Patients who carry dental insurance understand that all services furnished are charged directly to the patient who is personally responsible for payment of all services. This office will help prepare the insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by your insurance company. *Payment is due the day services are rendered unless prior financial arrangements have been made.*

I hereby authorize this office to process any dental claims and receive payment from my insurance company. I certify that the above information is accurate and complete to the best of my knowledge.

Signature: _____Date: _____ Relationship to Patient: _____

Patient Consent Form

Under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I understand that I have certain rights to privacy concerning my protected health information. I know that this information can and will be used:

- *Conduct, plan and direct my treatment and follow-up among various healthcare providers who may be involved in the treatment directly and indirectly.*
- *Conduct normal healthcare operations such as quality assessments and physician certifications.*
- *Obtain payment from third party payers.*

I have been informed by you of your *Notice of Privacy Practices* that contains a more complete description of the uses and disclosures of my health information. I have been given the right to review *Notice of Privacy Practices* prior to signing this form. I understand that this organization has the right to change its *Notice of Privacy* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices*.

I am aware that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by the restrictions.

I understand that I may revoke this consent form in writing at any time, except to the extent that you have taken action relying on this consent.

Signature: _____ Date:_____ Relationship to patient:_____