Medical History Form

Date _____

Name _____ (Last / First / Middle) Home Phone ( ) _____

Address _____ (Number, Street) Business Phone ( ) _____

City _____ State _____ Zip Code _____

Occupation _____ Social Security No. _____

Date of Birth ___/___/___ (mo. day yr.) Sex M F Height _____ Weight _____ Single _____ Married _____

Name of Spouse _____ Closest Relative _____ Phone ( ) _____

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

Referred by _____

For the following questions, *circle yes or no*, whichever applies. Your answers are for our records only and will be considered confidential. 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.

1. Are you in good health? . . . . . Yes No
2. Has there been any change in your general health within the past year? . . . . . Yes No
3. My last physical examination was on _____
4. Are you now under the care of a physician? . . . . . Yes No
   If so, what is the condition being treated? _____
5. The name and address of my physician(s) is _____
   _____
   _____
6. Have you had any serious illness, operation, or been hospitalized in the past 5 years? . . . . . Yes No
   If so, what was the illness or problem? _____
7. Are you taking any medicine(s) including non-prescription medicine?. . . . . Yes No
   If so, what medicine(s) are you taking? _____
8. Do you have or have you had any of the following diseases or problems?
   a. Damaged heart valves or artificial heart valves, including heart murmur or rheumatic heart disease . . . . . Yes No
   b. Cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke) . . . . . Yes No
      1. Do you have chest pain upon exertion? . . . . . Yes No
      2. Are you ever short of breath after mild exercise or when lying down? . . . . . Yes No
      3. Do your ankles swell? . . . . . Yes No
      4. Do you have inborn heart defects? . . . . . Yes No
      5. Do you have a cardiac pacemaker? . . . . . Yes No
   c. Allergy . . . . . Yes No
   d. Sinus trouble . . . . . Yes No
   e. Asthma or hay fever . . . . . Yes No
   f. Fainting spells or seizures . . . . . Yes No
   g. Persistent diarrhea or recent weight loss . . . . . Yes No
   h. Diabetes . . . . . Yes No
   i. Hepatitis, jaundice or liver disease . . . . . Yes No
   j. AIDS or HIV infection . . . . . Yes No
   k. Thyroid problems . . . . . Yes No
   l. Respiratory problems, emphysema, bronchitis, etc. . . . . Yes No
   m. Arthritis or painful swollen joints . . . . . Yes No
   n. Stomach ulcer or hyperacidity . . . . . Yes No
   o. Kidney trouble . . . . . Yes No
   p. Tuberculosis . . . . . Yes No
   q. Persistent cough or cough that produces blood . . . . . Yes No
   r. Persistent swollen glands in neck . . . . . Yes No
   s. Low blood pressure . . . . . Yes No
   t. Sexually transmitted disease . . . . . Yes No
   u. Epilepsy or other neurological disease . . . . . Yes No
   v. Problems with mental health . . . . . Yes No
   w. Cancer . . . . . Yes No
   x. Problems of the immune system . . . . . Yes No

(over)

9. Have you had abnormal bleeding? . . . . . Yes No
   a. Have you ever required a blood transfusion? . . . . . Yes No
10. Do you have any blood disorder such as anemia? . . . . . Yes No
11. Have you ever had any treatment for a tumor or growth? . . . . . Yes No
12. Are you allergic or have you had a reaction 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
13. Have you had any serious trouble associated with any previous dental treatment? . . . . . Yes No
   If so, explain _____
   _____
14. Do you have any disease, condition, or problem not listed above that you think I should know about? . . . . . Yes No
   If so, explain _____
   _____
15. Are you wearing contact lenses? . . . . . Yes No
16. Are you wearing removable dental appliances? . . . . . Yes No

Women

17. Are you pregnant? . . . . . Yes No
18. Do you have any problems associated with your menstrual period? . . . . . Yes No
19. Are you nursing? . . . . . Yes No
20. Are you taking birth control pills? . . . . . Yes No

Chief Dental Complaint _____
_____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the 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 errors or omissions that I may have made in the completion of this form.

_____
Signature of Patient

For completion by the dentist.

Comments on patient interview concerning medical history: _____
_____
_____
_____

Significant findings from questionnaire or oral interview: _____
_____
_____
_____

Dental management considerations: _____
_____
_____
_____

_____
(Date)

_____
Signature of Dentist

Medical history update:

Date	Comments	Signature
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Drs. DiVincenzo & Lefkowitz
312 Academy Street
Jersey City, NJ 07306

PLEASE LIST ANY MEDICINE(S) INCLUDING NON-PRESCRIPTION MEDICINE YOU ARE CURRENTLY TAKING

Medication	Dosage	Times/day

Patient's Name: _____

Signature: _____

Date: _____

Drs. DiVincenzo & Lefkowitz
312 ACADEMY STREET
JERSEY CITY, NJ 07306

Do you have Dental Insurance? ( ) yes ( ) no

A. Dental Insurance

PrimaryInsurance Subscriber's Name _____
Relationship to patient _____
Insurance Company _____
Subscriber's Birthdate _____ ***Subscriber's SS#*** _____
Group # _____

Is patient covered by **additional** insurance? ( ) Yes ( ) No

Secondary Subscriber's Name _____
Relationship to Patient _____
Insurance Company _____
Birthdate _____ ***SS#*** _____
Group # _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Drs. DiVincenzo and Lefkowitz all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorized the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____
Responsible Party – Print Name Signature

_____ _____
Relationship Date

Drs. DiVincenzo & Lefkowitz
312 ACADEMY STREET
JERSEY CITY, NJ 07306
201.216.9191

ASSIGNMENT AND RELEASE

I understand that I am financially responsible for all charges. I understand that all fees are due on the date of service.

Responsible Party – Print Name	Signature
Relationship	Date

Drs. DiVincenzo & Lefkowitz
312 ACADEMY STREET
JERSEY CITY, NJ 07306

PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company):
- The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information, and my right under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Date: _____

Print Patient Name: _____

Relationship to Patient: _____

Signature: _____

Giorgio T. DiVincenzo, DMD
David Lefkowitz, DDS
312 Academy Street
Jersey City, NJ 07306

Name: _____ Date_____

How do you prefer we contact you to confirm your appointment?

Text (Cell #) _____

E-Mail _____

Phone

Home _____

Business _____