Dental Health History Form

Today's Date _____

Patient Name: First _____ MI ____ Last _____ Nickname _____

What are your goals in coming to our practice today? _____

What is important to you in a dentist or dental practice? _____

What has been your experience with the dentist in the past? _____

Date of last radiographs (x-rays) and exam _____

Date of last hygiene continuing care appointment *(cleaning or periodontal maintenance)* _____

Former Dentist _____ **Phone** _____

Address: Street _____ City _____ State _____ Zip _____

If you left your previous dentist, what are the reasons? _____

Have you had problems with prior dental treatment? _____

Are you experiencing any pain now? ☐ Yes ☐ No

If yes, please describe _____

Have you ever been pre-medicated for dental treatment? ☐ Yes ☐ No

If yes, why? _____

Have you been anxious about having dental treatment? ☐ Yes ☐ No

If yes, would you be comfortable sharing why? _____

Would you like to discuss this concern with the doctor to learn about your relaxation options? _____

What concerns do you currently have with your oral health or smile? *(check all that apply)*

☐ Jaw joint pain
☐ Clenching or grinding of teeth
☐ Discolored teeth
☐ Crowding/Crooked teeth
☐ Missing teeth
☐ Spaces in between teeth
☐ Loose tooth/teeth
☐ Tooth shape or size
☐ Unhappy with appearance of teeth
☐ Overbite
☐ Underbite
☐ Uncomfortable bite
☐ Old fillings *(gold or silver)*
☐ Old crowns
☐ Speech problems
☐ Too much gum tissue when I smile
☐ Tooth sensitivity to hot/cold or anything else
☐ Food gets caught in between teeth
If yes, where? _____
☐ Difficulty chewing
If yes, where? _____
☐ Bad breath
☐ Other _____

Have you ever had orthodontic treatment? ☐ Yes ☐ No

If yes, when? _____

Have you ever had periodontal (gum tissue) treatment, such as deep cleanings, root planing, or periodontal surgery? ☐ Yes ☐ No

If yes, when? _____

Have you whitened your teeth in the past? ☐ Yes ☐ No

If yes, what method? _____

Are you interested in learning more about the following? *(check all that apply)*

☐ Teeth Whitening
☐ How to prevent periodontal disease
☐ At-home oral hygiene care
☐ Oral hygiene care for infants and toddlers
☐ Cosmetic Veneers
☐ Dental implants
☐ Orthodontic treatment
☐ Periodontal treatment during pregnancy
☐ Tooth-colored fillings

CONFIDENTIAL HEALTH HISTORY

Patient Name: _____ **Date of Birth:** _____

I. CIRCLE APPROPRIATE ANSWER (Leave blank if you do not understand the question)

1. Yes / No Is your general health good?
   If NO, explain: _____
2. Yes / No Has there been a change in your health within the last year?
   If YES, explain: _____
3. Yes / No Have you gone to the hospital or emergency room or had a serious illness in the last three years?
   If YES, explain: _____
4. Yes / No Are you being treated by a physician now? If YES, explain: _____
   Date of last medical exam? _____ Reason for exam: _____
5. Yes / No Have you had problems with prior dental treatment?
   If YES, explain: _____
   Date of last dental exam: _____ **Name of last treating dentist:** _____
6. Yes / No Are you in pain now?
   If YES, explain: _____

II. HAVE EVER YOU EXPERIENCED ANY OF THE FOLLOWING? (Please circle Yes or No for each)

Yes / No	Chest pain (angina)	Yes / No	Blood in stools	Yes / No	Frequent vomiting
Yes / No	Fainting spells	Yes / No	Diarrhea or constipation	Yes / No	Jaundice
Yes / No	Recent significant weight loss	Yes / No	Frequent urination	Yes / No	Dry mouth
Yes / No	Fever	Yes / No	Difficulty urinating	Yes / No	Excessive thirst
Yes / No	Night sweats	Yes / No	Ringing in ears	Yes / No	Difficulty swallowing
Yes / No	Persistent cough	Yes / No	Headaches	Yes / No	Swollen ankles
Yes / No	Coughing up blood	Yes / No	Dizziness	Yes / No	Joint pain or stiffness
Yes / No	Bleeding problems	Yes / No	Blurred vision	Yes / No	Shortness of breath
Yes / No	Blood in urine	Yes / No	Bruise easily	Yes / No	Sinus problems

Other: _____

III. HAVE YOU EVER HAD OR DO YOU HAVE ANY OF THE FOLLOWING? (Please circle Yes or No for each)

Yes / No	Heart disease	Yes / No	AIDS/HIV	Yes / No	Psychiatric care
Yes / No	Family history of heart disease	Yes / No	Surgeries	Yes / No	Osteoporosis
Yes / No	Heart attack	Yes / No	Hospitalization	Yes / No	Thyroid disease
Yes / No	Artificial joint	Yes / No	Diabetes	Yes / No	Asthma
Yes / No	Stomach problems or ulcers	Yes / No	Family history of diabetes	Yes / No	Hepatitis
Yes / No	Heart defects	Yes / No	Tumors or cancer	Yes / No	Sexual transmitted disease
Yes / No	Heart murmurs	Yes / No	Chemotherapy	Yes / No	Herpes
Yes / No	Rheumatic fever	Yes / No	Radiation	Yes / No	Canker or cold sores
Yes / No	Skin disease	Yes / No	Arthritis, rheumatism	Yes / No	Anemia
Yes / No	Hardening of arteries	Yes / No	Emphysema or other lung disease	Yes / No	Liver disease
Yes / No	High blood pressure	Yes / No	Kidney or bladder disease	Yes / No	Eye disease
Yes / No	Seizures	Yes / No	Stroke	Yes / No	Transplants
Yes / No	Cosmetic surgery	Yes / No	Eating disorders	Yes / No	Tuberculosis

Other: _____

IV. ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING? (Please circle Yes or No for each)

Yes / No	Aspirin	Yes / No	Valium or other sedatives	Yes / No	Codeine or other narcotics
Yes / No	Penicillin or other antibiotics	Yes / No	Latex	Yes / No	Food
Yes / No	Nitrous oxide	Yes / No	Local anesthetic	Yes / No	Metal

Others: _____

V. ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE LAST THREE MONTHS?
(Please circle Yes or No for each)

Yes / No	Recreational drugs	Yes / No	Tobacco in any form	Yes / No	Antibiotics
Yes / No	Over-the-counter medicines	Yes / No	Alcohol	Yes / No	Supplements
Yes / No	Weight loss medications	Yes / No	Bisphosphonate (Fosamax)	Yes / No	Aspirin
Yes / No	Anti-Depressants	Yes / No	Herbal supplements		

Please list all prescription medications: _____

VI. WOMEN ONLY (Please circle Yes or No for each)

Yes / No **Are you or could you be pregnant? If YES, what month?** _____

Yes / No **Are you nursing?**

Yes / No **Are you taking birth control pills?**

VII. ALL PATIENTS (Please circle Yes or No for each)

Yes / No **Do you have or have you had any other diseases or medical problems NOT listed on this form?**
If YES, please explain: _____

_____

Yes / No Have you ever been pre-medicated for dental treatment? If YES, why: _____

Yes / No Have you ever taken Fen-Phen? If YES, when: _____

Yes / No **Is there any issue or condition that you would like to discuss with the dentist in private?**

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically compromised situation, medical consultation may be needed prior to commencement of dental treatment.

I authorize the dentist to contact my physician.

Patient's Signature: _____ **Date:** _____

Physician's Name: _____ **Phone Number:** _____

Whom would you like us to contact in case of an emergency?

Name: _____ **Relationship:** _____ **Phone Number:** _____

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further, 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 (Parent or Guardian)	**Date**	**Signature of Dentist**	**Date**

MEDICAL UPDATES
I have reviewed my Health History and confirm that it accurately states past and present conditions.

DATE	**PATIENT SIGNATURE INITIALS**	**CHANGES TO HEALTH HISTORY**	**DENTIST**
_____	_____	_____	
_____	_____	_____	
_____	_____	_____	
_____	_____	_____	
_____	_____	_____	
_____	_____	_____	

Patient Information Form

Today's Date _____

Patient Name: First _____ MI _____ Last _____ Nickname _____

Address: Street _____ City _____ State _____ Zip _____

Phone: Home _____ Work _____ Mobile _____

Social Security Number _____ Date of Birth _____

Drivers License # _____ State _____

Patient Employed By _____ Occupation _____ Phone _____

Address: Street _____ **City** _____ **State** _____ **Zip** _____

Sex ___ Male ___ Female **Marital Status** ____ Married ____ Single ____ Divorced _____ Separated _____ Widowed

In case of emergency, who should be notified? _____

Relationship to Patient _____ Home Phone _____ Mobile Phone _____

Is the patient a Minor? ____ Yes ___ No **Full-time Student** ___ Yes ___ No **Name of School** _____

Name of Responsible Party: First _____ Last _____

Date of Birth _____ **Relationship to Patient** ___ Self ___ Spouse ___ Parent ____ Other _____

If patient is a Minor, primary residency ___ Both Parents ___ Mom ___ Dad ___ Step Parent ___ Shared Custody ___ Guardian

Address: *(if different from patient)* Street _____ City _____ State _____ Zip _____

Phone: Home _____ Work Mobile _____

Employer *(if different from above)* _____ Occupation _____ Phone _____

Address: Street _____ City _____ State _____ Zip _____

Dental Benefit Plan Information

Primary Dental Plan Name _____ Phone _____

Address: Street _____ City _____ State _____ Zip _____

Name of Insured _____ Date of Birth _____ ID Number _____

Policy Number _____ Patient Relationship to Insured _____

Secondary Dental Plan Name _____ Phone _____

Address: Street _____ City _____ State _____ Zip _____

Name of Insured _____ Date of Birth _____ ID Number _____

Policy Number _____ Patient Relationship to Insured _____

Medical Plan Information

Plan Name _____ Phone _____

Address: Street _____ City _____ State _____ Zip _____

Name of Insured _____ Date of Birth _____ ID Number _____

Policy Number _____

Patient Relationship to Insured _____

Deductible Amount _____

Whom may we thank for referring you?

☐ **One of our valued patients (name of patient)** _____

☐ Advertisement _____ Local Dental Society _____

☐ Our Website _____ Other _____

☐ Websearch _____ Direct mailer/postcard _____

Please list other members of your immediate family who are patients in our practice

_____ _____ _____ _____

R.J. SONDKAR DDS INC

Notice of Privacy Practices

PATIENT NAME_____DATE_____

This Notice describes how your health information 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

Federal and state laws require us to maintain the privacy of your health information. We are also required to provide this Notice about our office's privacy practices, our legal duties, and your rights regarding your health information. We are required to follow the practices that are outlined in this Notice while it is in effect. This Notice takes effect today 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 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. For more information about our privacy practices or additional copies of this Notice, please contact us (contact information below).

Uses and Disclosures of Health Information
We use and disclose health information about you for treatment, payment, and healthcare operations.
For example:
Treatment:
We disclose medical information to our employees and others who are involved in providing the care you need. We may use or disclose your health information to another dentist or other healthcare providers providing treatment that we do not provide. We may also share your health information with a pharmacist in order to provide you with a prescription, or with a laboratory that performs tests or fabricates dental prostheses or orthodontic appliances.
Payment:
We may use and disclose your health information to obtain payment for services we provide you, unless you request that we restrict such disclosure to your health plan when you have paid out-of-pocket and in full for services rendered.
Healthcare Operations:
We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include, but are not limited to, 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 affect any use or disclosures permitted by your authorization while it is 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. You have the right to request restrictions on disclosure to family members, other relatives, close personal friends, or any other person identified by you.
Unsecured Email:
We will not send you unsecured emails pertaining to your health information without your prior authorization. If you do authorize communications via unsecured email, you have the right to revoke the authorization at any time.
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 may contact you about products or services related to your treatment, case management or care coordination, or to propose other treatments or health-related benefits and services in which you may be interested. We may also encourage you to purchase a product or service when you visit our office. If you are currently an enrollee of a dental plan, we may receive payment for communications to you in relation to our provision, coordination, or management of your dental care, including our coordination or management of your health care with a third party, our consultation with other health care providers relating to your care, or if we refer you for health care. We will not otherwise use or disclose your health information for marketing purposes without you written authorization. We will disclose whether we receive payments for marketing activity you have authorized.

Change of Ownership:

If this dental practice is sold or merged with another practice or organization, your health records will become the property of the new owner. However, you may request that copies of your health information be transferred to another dental practice.

Required by Law:

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

Public Health:

We may, and are sometimes legally obligated, to disclose your health information to public health agencies for purposes related to preventing or controlling disease, injury or disability; reporting abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. Upon reporting suspected elder or dependent adult abuse or domestic violence, we will promptly inform you or your personal representative unless we believe the notification would place you at risk of harm or would require informing a personal representative we believe is responsible for the abuse or harm.

Abuse or Neglect:

We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security:

We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmates or patients under certain circumstances.

Appointment Reminders:

We may contact you to provide you with appointment reminders via voicemail, postcards, or letters. We may also leave a message with the person answering the phone if you are not available.

Sign In Sheet and Announcement:

Upon arriving at our office, we may use and disclose medical information about you by asking that you sign an intake sheet at our front desk. We may also announce your name when we are ready to see you.

Patient Rights

Access:

You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by contacting our office. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter. If you request copies, there may be a charge for time spent. If you request an alternate format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us for a full explanation of our fee structure.

Disclosure Accounting:

You have a right to receive a list of instances in which we disclosed your health information for purposes other than treatment, payment, healthcare operations and certain other activities for the last six years. If you request this accounting more than once in a 12-month period, we may charge you a reasonable cost-based fee for responding to these additional requests.

Restriction:

You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in emergency). In the event you pay out-of-pocket and in full for services rendered, you may request that we not share your health information with your health plan. We must agree to this request.

Alternative Communication:

You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request.

Breach Notification:

In the event your unsecured protected health information is breached, we will notify you as required by law. In some situations, you may be notified by our business associates.

Amendment:

You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended). We may deny your request under certain circumstances.

Questions and Complaints:

If you want more information about our privacy practices or have questions or concerns, please contact us at:

Contact: _____

Telephone: _____ Fax: _____

E-mail: _____

Address: _____

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may send a written complaint to our office or to the U.S. Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

Continued over to the next page >>>>>>>>>>>>>>>>>>>>

RJ Sondkar DDS Inc.

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, have received a copy of the Notice of Privacy Practices from RJ Sondkar DDS Inc.

[Please Print Name]_____

[Signature]_____

[Date]_____

If this Acknowledgement is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's name_____

Relationship to Patient _____

For Program Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

Dental office Staff Signature_____

Staff member name _____

Date_____