Health History Form

ADA American Dental Association®

America's leading advocate for oral health

E-mail: Today's Date:

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: (Last / First / Middle)
Home Phone: *Include area code* ( )
Business/Cell Phone: *Include area code* ( )

Address: (Mailing address)
City:
State:
Zip:

Occupation:
Height:
Weight:
Date of birth:
Sex: M F

SS# or Patient ID:
Emergency Contact:
Relationship:
Home Phone: ( )
Cell Phone: ( )
Include area codes

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

Your Name
Relationship

Do you have any of the following diseases or problems: ***(Check DK if you Don't Know the answer to the question)***

	Yes	No	DK
Active Tuberculosis	☐	☐	☐
Persistent cough greater than a 3 week duration	☐	☐	☐
Cough that produces blood	☐	☐	☐
Been exposed to anyone with tuberculosis	☐	☐	☐

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Dental Information

For the following questions, please mark (X) your responses to the following questions.

	Yes	No	DK
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Does food or floss catch between your teeth?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐
Do you drink bottled or filtered water?	☐	☐	☐
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY			
Are you currently experiencing dental pain or discomfort?	☐	☐	☐

	Yes	No	DK
Do you have earaches or neck pains?	☐	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Do you brux or grind your teeth?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Do you participate in active recreational activities?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐

Date of your last dental exam:
What was done at that time?

Date of last dental x-rays:

What is the reason for your dental visit today?

How do you feel about your smile?

Medical Information

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No	DK
Are you now under the care of a physician?	☐	☐	☐

Physician Name:
Phone: *Include area code* ( )

Address/City/State/Zip:

	Yes	No	DK
Are you in good health?	☐	☐	☐
Has there been any change in your general health within the past year?	☐	☐	☐

If yes, what condition is being treated?

Date of last physical exam:

	Yes	No	DK
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐	☐

If yes, what was the illness or problem?

	Yes	No	DK
Are you taking or have you recently taken any prescription or over the counter medicine(s)?	☐	☐	☐

If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements:

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Form S500

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

(Check DK if you Don't Know the answer to the question) — Yes / No / DK

Do you wear contact lenses? ☐ ☐ ☐

Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? ☐ ☐ ☐
Date: ____________ If yes, have you had any complications?______________

Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease? ☐ ☐ ☐

Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? ☐ ☐ ☐
Date Treatment began: ______________________________

Do you use controlled substances (drugs)? ☐ ☐ ☐

Do you use tobacco (smoking, snuff, chew, bidis)? ☐ ☐ ☐
If so, how interested are you in stopping?
(Check one) ☐ VERY ☐ SOMEWHAT ☐ NOT INTERESTED

Do you drink alcoholic beverages? ☐ ☐ ☐
If yes, how much alcohol did you drink in the last 24 hours? ______________
If yes, how much do you typically drink In a week? ______________

WOMEN ONLY Are you:
Pregnant? ☐ ☐ ☐
Number of weeks: ____________
Taking birth control pills or hormonal replacement? ☐ ☐ ☐
Nursing? ☐ ☐ ☐

Allergies - Are you allergic to or have you had a reaction to:
To all **yes** responses, specify type of reaction.

Allergy	Yes	No	DK
Local anesthetics ______	☐	☐	☐
Aspirin ______	☐	☐	☐
Penicillin or other antibiotics ______	☐	☐	☐
Barbiturates, sedatives, or sleeping pills ______	☐	☐	☐
Sulfa drugs ______	☐	☐	☐
Codeine or other narcotics ______	☐	☐	☐
Metals ______	☐	☐	☐
Latex (rubber) ______	☐	☐	☐
Iodine ______	☐	☐	☐
Hay fever/seasonal ______	☐	☐	☐
Animals ______	☐	☐	☐
Food ______	☐	☐	☐
Other ______	☐	☐	☐

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

Condition	Yes	No	DK
Artificial (prosthetic) heart valve	☐	☐	☐
Previous infective endocarditis	☐	☐	☐
Damaged valves in transplanted heart	☐	☐	☐
Congenital heart disease (CHD)			
Unrepaired, cyanotic CHD	☐	☐	☐
Repaired (completely) in last 6 months	☐	☐	☐
Repaired CHD with residual defects	☐	☐	☐

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

Condition	Yes	No	DK
Cardiovascular disease.	☐	☐	☐
Angina	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Congestive heart failure	☐	☐	☐
Damaged heart valves	☐	☐	☐
Heart attack	☐	☐	☐
Heart murmur	☐	☐	☐
Low blood pressure	☐	☐	☐
High blood pressure	☐	☐	☐
Other congenital heart defects	☐	☐	☐
Mitral valve prolapse	☐	☐	☐
Pacemaker	☐	☐	☐
Rheumatic fever	☐	☐	☐
Rheumatic heart disease	☐	☐	☐
Abnormal bleeding	☐	☐	☐
Anemia	☐	☐	☐
Blood transfusion	☐	☐	☐
If yes, date:______			
Hemophilia	☐	☐	☐
AIDS or HIV infection	☐	☐	☐
Arthritis	☐	☐	☐
Autoimmune disease	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Systemic lupus erythematosus.	☐	☐	☐
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐
Tuberculosis	☐	☐	☐
Cancer/Chemotherapy/ Radiation Treatment	☐	☐	☐
Chest pain upon exertion	☐	☐	☐
Chronic pain	☐	☐	☐
Diabetes Type I or II	☐	☐	☐
Eating disorder	☐	☐	☐
Malnutrition	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
G.E. Reflux/persistent heartburn	☐	☐	☐
Ulcers	☐	☐	☐
Thyroid problems	☐	☐	☐
Stroke	☐	☐	☐
Glaucoma	☐	☐	☐
Hepatitis, jaundice or liver disease	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Neurological disorders	☐	☐	☐
If yes, specify:______			
Sleep disorder	☐	☐	☐
Mental health disorders	☐	☐	☐
Specify:______			
Recurrent Infections	☐	☐	☐
Type of infection:______			
Kidney problems	☐	☐	☐
Night sweats	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistent swollen glands in neck	☐	☐	☐
Severe headaches/ migraines	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
Excessive urination	☐	☐	☐

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ☐ ☐ ☐

Name of physician or dentist making recommendation: Phone:

Do you have any disease, condition, or problem not listed above that you think I should know about? ☐ ☐ ☐
Please explain:

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about 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 action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: Date:

FOR COMPLETION BY DENTIST

NEHA P. SHAH, DMD♦11 Deerfield Place♦Flanders, NJ 07836♦973.668.5020

Office Policy

PATIENT INFORMATION:
Name____
Referring Dentist_____________________________________

PRIMARY INSURANCE INFORMATION:
Name of Insured (if other than the patient): ____
Relationship to Patient_________________ Social Security Number of Insured: ______________________
Dental Insurance_______________________________ Date of Birth of Insured:______________________
Employer of Insured: __________________________ Group Number: ____________________________
ID/Subscriber #: ___________________________ Insurance Phone Number: _______________________

SECONDARY INSURANCE INFORMATION:
Name of Insured (if other than the patient): ____
Relationship to Patient_________________ Social Security Number of Insured: ________________________
Dental Insurance_______________________________ Date of Birth of Insured:________________________
Employer of Insured: __________________________ Group Number: ________________________________
ID/Subscriber #: ___________________________ Insurance Phone Number: __________________________

Providing you with superior periodontal care to maintain your optimum dental health is our first priority.

- We make all payment arrangements in advance so you as a patient and we as your caregiver can focus completely on your dental treatment.
- For your convenience, we accept the following methods of payment: Cash, Checks, Debit, & Credit Cards. *We also participate in Care Credit, a no-interest financing option.* Please contact us for more information.
- ***Your estimated co-payment is due at the time of your visit. Although our office will do our best to determine your insurance benefits, ultimately it is your responsibility to pay any unpaid balance. We cannot know until services are COMPLETED what the insurance company will actually pay.***
- In the event we are not able to collect payment, we are obligated to inform you that your case will be referred to a certified collection agency. If your account is sent to collections you will be responsible for up to an 18% interest yearly on your balance as well as 30-50% of collection agency fees on your unpaid balance.
- We strive to provide you with the utmost, effective, and convenient care possible. With this in mind, it is understandable why we value the time scheduled for your appointment. This time is reserved especially for you. Our policy requires 2 business days notification for all cancellations.
- If at any time, you have concerns regarding financial matters with our office, please contact us immediately so we may assist you.

Welcome to our practice!

I have read and understood the above agreement.

______________________________ ______________________________ ____________________

Patient Name Patient Signature Date

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

NEHA P. SHAH, DMD
11 DEERFIELD PLACE
FLANDERS, NJ 07836
973.668.5020

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 (HIPPA). I understand that by signing this consent I authorize you to use and disclose my protected health information to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and individually.
- Obtain payment from third party payers. (e.g. my insurance company)
- Conduct normal health-care operations such as quality assessments, dentist certifications, request x-rays, records, and reports

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of any health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to receive a current copy of the Notice of Private Practices.

I understand 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 that you are not required to agree to my restrictions, but if you do agree then you are bound to abide by such restrictions.

____________________________ ____________________________ __________________

Patient Name Patient Signature Date

Authorization to Release Information:

I authorize the above named dentist to provide any insurance company, claim administrators, and consulting healthcare professional, information concerning health care, advice, treatment, or supplies provided. This information will be use exclusively for the purpose of evaluation and administering claims for benefits.

I hereby authorize payment of the dental benefits otherwise payable directly to the above named entity.

____________________________ ____________________________ __________________

Patient Name Patient Signature Date

Authorization and Consent
To Send Unencrypted Patient Information by Email and Other Electronic Means

Until I tell you in writing to stop, I authorize, Neha P. Shah, DMD LLC, to transmit patient information relating to my treatment, health, or payment by email or other electronic means, without encryption or special security precautions, to me or someone I designate, or to other health care providers, health plans and others involved in my treatment, payment for my treatment, or Neha P. Shah, DMD LLC health care operations. The patient information that may be emailed may include my x-rays, health history, diagnosis, treatment, and payment records.

I understand that:

- I do not have to sign this form.
- My treatment, payment, enrollment and eligibility for benefits will not be affected by my decision about signing this form.
- If I don't sign this form, Neha P. Shah, DMD LLC may use other ways to send my information, such as U.S. Mail, or may ask me to send my information to third parties myself.
- There is some risk that emails and other electronic messages may be improperly acquired by hackers or received by unintended recipients. If that happens, the information may be redisclosed and no longer protected by privacy law.
- Neha P. Shah, DMD LLC does not email such sensitive personal information as Social Security number, credit card number, mental health diagnosis, genetic information, alcohol/substance abuse, or positive HIV status unless the patient insists.

I can tell you in writing to stop emailing my patient information at any time, but if I do so, this will not affect emails that Neha P. Shah, DMD LLC already sent before receiving my written instructions to stop.

Patient name (please print) ________________________

Signature: ______________________________________ Date: ________________