PATIENT MEDICAL HISTORY

Patient's Name:

For Office Use Only
ID:

Address: | **Today's Date:** | **Date of Last Visit:** | **Date of Med. History:**

City State Zip: | **Email:**

Home Phone: | **Work Phone:** | **Cell Phone:** | **Birth Date:** | **Social Security No.:** | **Marital Status:**

Primary Dental Guarantor: | **Home Phone:** | **Work Phone:** | **Cell Phone:**

Secondary Dental Guarantor: | **Home Phone:** | **Work Phone:** | **Cell Phone:**

Physician Name: | **Physician Phone:**

Pharmacy: | **Pharmacy Phone:**

For Office Use Only
Medical Alerts:

Sex:

If female please answer the following:

Y N
- ☐ ☐ Are you taking Birth Control Pills?
- ☐ ☐ Are you pregnant? If Yes, # of weeks ☐
- ☐ ☐ Are you nursing?

Please answer the following:

Y N
- ☐ ☐ Do you smoke or use tobacco?

For Office Use Only
BP: Heart Rate:

Height:

Weight:

Y N	Conditions
☐ ☐	Abnormal Bleeding
☐ ☐	Alcohol Abuse
☐ ☐	Allergies
☐ ☐	Anemia
☐ ☐	Angina Pectoris
☐ ☐	Arthritis
☐ ☐	Artificial Heart Valve
☐ ☐	Artificial Joint
☐ ☐	Asthma
☐ ☐	Blood Thinners
☐ ☐	Blood Transfusion
☐ ☐	Cancer- Chemotherapy
☐ ☐	Colitis
☐ ☐	Congenital Heart Defect
☐ ☐	Diabetes
☐ ☐	Drug Abuse
☐ ☐	Emphysema
☐ ☐	Endocarditis
☐ ☐	Epilepsy
☐ ☐	Fainting Spells
☐ ☐	Frequent Headaches
☐ ☐	Glaucoma

Y N	Conditions
☐ ☐	HIV+ AIDS
☐ ☐	Heart Attack
☐ ☐	Heart Surgery
☐ ☐	Hemophilia
☐ ☐	Hepatitis
☐ ☐	High Blood Pressure
☐ ☐	Kidney Problems
☐ ☐	Liver Disease
☐ ☐	Low Blood Pressure
☐ ☐	Osteoporosis Medications (Bisphos
☐ ☐	Osteoporosis/Osteopenia
☐ ☐	Pace Maker
☐ ☐	Psychiatric Problems
☐ ☐	Radiation Therapy
☐ ☐	Rheumatic Fever
☐ ☐	Seizures
☐ ☐	Sickle Cell Disease
☐ ☐	Taken Fen-Phen
☐ ☐	Tuberculosis
☐ ☐	Sinus Problems
☐ ☐	Stroke
☐ ☐	GERD (Acid Reflux)

Y N	Conditions
☐ ☐	STI
☐ ☐	Cold Sores
☐ ☐	Daily Aspirin
☐ ☐	Organ Transplant
☐ ☐	Vitamins/Supplements
☐ ☐	Thyroid Problem

Y N	Allergies
☐ ☐	Aspirin
☐ ☐	Codeine
☐ ☐	Dental Anesthetics
☐ ☐	Erythromycin
☐ ☐	Jewelry
☐ ☐	Latex
☐ ☐	Metals
☐ ☐	Penicillin
☐ ☐	Tetracycline

Other

_____

_____

_____

Medications:

Y N

☐ ☐ **Is there any disease, condition, or problem that you think this office should know about that is not covered above? If yes, please describe below...**

Notes:

Signature: _____ **Date:** _____

(If Under 18, Parent or Guardian Signature Required)

CHARLES R. AVRUTIK, D.D.S.
395 RIDGE ROAD, SUITE 5
DAYTON, NJ 08810

INSURANCE INFORMATION

INSURED INFORMATION		
Name of Insured:		
Date of birth:	SSN:	Cell Phone:
Name of Employer:		
Address:		
City:	State:	ZIP Code:
Insurance Company Name:		
Group#:	ID#:	Phone#:
Address:		PPO_____DMO_____
City:	State:	ZIP Code:
SECONDARY INSURANCE		
Name of Insured:		
Date of Birth:	SSN:	Cell Phone:
Name of Employer:		
Address:		
City:	State:	ZIP Code:
Insurance Company Name:		
Group#:	ID#:	Phone#:
Address:		PPO_____DMO_____
City:	State:	ZIP Code:

Charles R. Avrutik, DDS
395 Ridge Road Suite 5
Dayton, NJ 08810
732-274-2544

As of April 14, 2003, Federal law requires Charles R. Avrutik, DDS to give his patients a "Notice of Privacy Practices". We must make a good-faith attempt to obtain written acknowledgement of receipt of the notice from the patient. By signing this form, you have acknowledged you have received the form from Charles R. Avrutik, DDS and completed the section "Patient Disclosure Information".

Patient Disclosure Information

I wish to be contacted in the following manner (check all that apply)

Home telephone_____

[ ] OK to leave message with detailed information
[ ] Leave message with call-back number only

Work telephone_____

[ ] OK to leave message with detailed information
[ ] Leave message with call-back number only

Written Medical Communication

[ ] OK to mail to my home address
[ ] OK to mail to my work/office address
[ ] OK to fax to this number_____

Other

_____
_____

Person authorized to receive information

_____**Relationship**_____ **Phone#**_____

_____**Relationship**_____ **Phone#**_____

_____**Relationship**_____ **Phone#**_____

Print Patient name:_____**Birthdate**_____

Signature:_____**Date**_____

CHARLES R. AVRUTIK, D.D.S.
395 RIDGE ROAD
DAYTON PROFESSIONAL CENTER, SUITE 5
DAYTON, NJ 08810-1398

SIGNATURE ON FILE AUTHORIZATON FORM

AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize the above named dentist to provide any Insurance company(s), claim administrator(s), and consulting health care professionals, information concerning health care, advice, treatment, or supplies provided. This information will be used exclusively for the purpose of evaluating and administering claims for benefits.
I permit a copy of this authorization to be used in place of the original.

My signature also applies to the dependents listed below.

_____ _____
SIGNATURE **DATE**

_____ _____
_____ _____
_____ _____

ASSIGNMENT OF INSURANCE BENEFITS:

I hereby authorize payment directly to Dr. Avrutik of the insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

My signature also applies to the dependents listed below.

_____ _____
SIGNATURE **DATE**

_____ _____
_____ _____
_____ _____

COVID-19 Patient Screening, Advisory, Acknowledgement

Receiving Dental Treatment During the COVID-19 Pandemic

Dear Patient,

You have come to our office today for a routine dental evaluation and/or treatment that will be done during the COVID-19 pandemic. Please be advised of the following:

While our office complies with the State of New Jersey Department of Health and the Centers for Disease Control and Prevention infection control guidelines to prevent the spread of the COVID-19 virus, we cannot make any guarantees.

Our staff are symptom-free and, to the best of their knowledge, have not been exposed to the virus. However, since we are a place of public accommodation, other persons (including other patients) could be infected, with or without their knowledge.

In order to reduce the risk of spreading COVID-19, we have asked you a number of screening questions below. For the safety of our staff, other patients, and yourself, please be truthful and candid in your answers. Thank you.

Screening Questions	**Date:** **Staff Initials:**	**Date:** **Staff Initials:**	**Notes**
Do you have a fever or above normal temperature (<100.0°F)? *Take temperature at appointment.*	☐ Yes ☐ No	☐ Yes ☐ No	
Are you experiencing shortness of breath or having trouble breathing?	☐ Yes ☐ No	☐ Yes ☐ No	
Do you have a dry cough?	☐ Yes ☐ No	☐ Yes ☐ No	
Do you have a runny nose?	☐ Yes ☐ No	☐ Yes ☐ No	
Do you have sneezing, watery eyes, and/or sinus pain/pressure that is unusual and not related to seasonal allergies?	☐ Yes ☐ No	☐ Yes ☐ No	
Have you recently lost or had a reduction in your taste or smell?	☐ Yes ☐ No	☐ Yes ☐ No	

Do you have a sore throat?	☐ Yes ☐ No	☐ Yes ☐ No	
Are you experiencing chills or repeated shaking with chills?	☐ Yes ☐ No	☐ Yes ☐ No	
Do you have unexplained muscle pain or weakness?	☐ Yes ☐ No	☐ Yes ☐ No	
Do you have a headache?	☐ Yes ☐ No	☐ Yes ☐ No	
Even if you don't currently have any of the above symptoms, have you experienced any of these symptoms in the last 14 days?	☐ Yes ☐ No	☐ Yes ☐ No	
Are you currently or have you in the last 14 days taken any fever reducing medications such as ibuprofen, naproxen, acetaminophen, etc.?	☐ Yes ☐ No	☐ Yes ☐ No	
Have you been in contact with someone who has tested positive for COVID-19 in the last 14 days?	☐ Yes ☐ No	☐ Yes ☐ No	
Have you been tested for COVID-19 in the last 14 days?	☐ Yes ☐ No	☐ Yes ☐ No	*Date of test (if applicable):*
If yes, *what is the result of the testing?* ***If still waiting on results,*** *schedule appointment after results are known.*	☐ Positive ☐ Negative	☐ Positive ☐ Negative	

I agree to notify the dental practice if within 14 days I become ill with COVID-19 symptoms or test positive for COVID-19. I understand the dental practice has a legal and ethical obligation to inform me if a staff person I had contact with tested positive for COVID-19 within 14 days.

Signature_____

Date_____

Charles R. Avrutik,D.D.S.

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.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 4/14/2013, 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, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice 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.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

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

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

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 institution or law enforcement official having lawful custody the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.