

# Health History Form

**ADA** American Dental Association®

America's leading advocate for oral health

Email:  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: <i>Last</i> <i>First</i> <i>Middle</i>	Home Phone: <i>Include area code</i> (   )	Business/Cell Phone: <i>Include area code</i> (   )
Address: <i>Mailing address</i>	City:	State:      Zip:
Occupation:	Height:	Weight:      Date of Birth:      Sex: M F
SS# or Patient ID:	Emergency Contact:	Relationship:      Home Phone: <i>Include area code</i> Cell Phone: <i>Include area code</i> (   )                      (   )

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

<i>Your Name</i>	<i>Relationship</i>
<b>Do you have any of the following diseases or problems:</b>	<i>(Check DK if you Don't Know the answer to the the question)</i>
Active Tuberculosis.....	Yes No DK <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Persistent cough greater than a 3 week duration.....	Yes No DK <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Cough that produces blood.....	Yes No DK <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Been exposed to anyone with tuberculosis.....	Yes No DK <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

**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		Yes No DK
Do your gums bleed when you brush or floss?.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you have earaches or neck pains?.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Are your teeth sensitive to cold, hot, sweets or pressure?.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you have any clicking, popping or discomfort in the jaw?.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Is your mouth dry?.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you brux or grind your teeth?.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Have you had any periodontal (gum) treatments?.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you have sores or ulcers in your mouth?.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Have you ever had orthodontic (braces) treatment?.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you wear dentures or partials?.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Have you had any problems associated with previous dental treatment?.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Do you participate in active recreational activities?.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Is your home water supply fluoridated?.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Have you ever had a serious injury to your head or mouth?.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Do you drink bottled or filtered water?.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Date of your last dental exam:	
If yes, how often? <i>Circle one: DAILY / WEEKLY / OCCASIONALLY</i>		What was done at that time?	
Are you currently experiencing dental pain or discomfort?.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	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		Yes No DK
Are you now under the care of a physician?.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Have you had a serious illness, operation or been hospitalized in the past 5 years?.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Physician Name:                      Phone: <i>Include area code</i> (   )		If yes, what was the illness or problem?	
Address/City/State/Zip:		Are you taking or have you recently taken any prescription or over the counter medicine(s)?.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Are you in good health?.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements:	
Has there been any change in your general health within the past year?.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	_____	
If yes, what condition is being treated?		_____	
Date of last physical exam:		_____	

# 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)

Do you wear contact lenses?  Yes  No  DK

**Joint Replacement.** Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?  Yes  No  DK

Date: \_\_\_\_\_ If yes, have you had any complications? \_\_\_\_\_

Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax®, Actonel®, Atelvia, Boniva®, Reclast, Prolia) for osteoporosis or Paget's disease?  Yes  No  DK

Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia®, Zometa®, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?  Yes  No  DK

Date Treatment began: \_\_\_\_\_

**Allergies.** Are you allergic to or have you had a reaction to: To all **yes** responses, specify type of reaction.  Yes  No  DK

Local anesthetics  Yes  No  DK

Aspirin  Yes  No  DK

Penicillin or other antibiotics  Yes  No  DK

Barbiturates, sedatives, or sleeping pills  Yes  No  DK

Sulfa drugs  Yes  No  DK

Codeine or other narcotics  Yes  No  DK

Do you use controlled substances (drugs)?  Yes  No  DK

Do you use tobacco (smoking, snuff, chew, bidis)?  Yes  No  DK

If so, how interested are you in stopping?  
Circle one: VERY / SOMEWHAT / NOT INTERESTED

Do you drink alcoholic beverages?  Yes  No  DK

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?  Yes  No  DK

Number of weeks: \_\_\_\_\_

Taking birth control pills or hormonal replacement?  Yes  No  DK

Nursing?  Yes  No  DK

Metals  Yes  No  DK

Latex (rubber)  Yes  No  DK

Iodine  Yes  No  DK

Hay fever/seasonal  Yes  No  DK

Animals  Yes  No  DK

Food  Yes  No  DK

Other  Yes  No  DK

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

Artificial (prosthetic) heart valve  Yes  No  DK

Previous infective endocarditis  Yes  No  DK

Damaged valves in transplanted heart  Yes  No  DK

Congenital heart disease (CHD)

Unrepaired, cyanotic CHD  Yes  No  DK

Repaired (completely) in last 6 months  Yes  No  DK

Repaired CHD with residual defects  Yes  No  DK

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

Cardiovascular disease  Yes  No  DK

Angina  Yes  No  DK

Arteriosclerosis  Yes  No  DK

Congestive heart failure  Yes  No  DK

Damaged heart valves  Yes  No  DK

Heart attack  Yes  No  DK

Heart murmur  Yes  No  DK

Low blood pressure  Yes  No  DK

High blood pressure  Yes  No  DK

Other congenital heart defects  Yes  No  DK

Mitral valve prolapse  Yes  No  DK

Pacemaker  Yes  No  DK

Rheumatic fever  Yes  No  DK

Rheumatic heart disease  Yes  No  DK

Abnormal bleeding  Yes  No  DK

Anemia  Yes  No  DK

Blood transfusion  Yes  No  DK

If yes, date: \_\_\_\_\_

Hemophilia  Yes  No  DK

AIDS or HIV infection  Yes  No  DK

Arthritis  Yes  No  DK

Autoimmune disease  Yes  No  DK

Rheumatoid arthritis  Yes  No  DK

Systemic lupus erythematosus  Yes  No  DK

Asthma  Yes  No  DK

Bronchitis  Yes  No  DK

Emphysema  Yes  No  DK

Sinus trouble  Yes  No  DK

Tuberculosis  Yes  No  DK

Cancer/Chemotherapy/  
Radiation Treatment  Yes  No  DK

Chest pain upon exertion  Yes  No  DK

Chronic pain  Yes  No  DK

Diabetes Type I or II  Yes  No  DK

Eating disorder  Yes  No  DK

Malnutrition  Yes  No  DK

Gastrointestinal disease  Yes  No  DK

G.E. Reflux/persistent  
heartburn  Yes  No  DK

Ulcers  Yes  No  DK

Thyroid problems  Yes  No  DK

Stroke  Yes  No  DK

Glaucoma  Yes  No  DK

Hepatitis, jaundice or  
liver disease  Yes  No  DK

Epilepsy  Yes  No  DK

Fainting spells or seizures  Yes  No  DK

Neurological disorders  Yes  No  DK

If yes, specify: \_\_\_\_\_

Sleep disorder  Yes  No  DK

Do you snore?  Yes  No  DK

Mental health disorders  Yes  No  DK

Specify: \_\_\_\_\_

Recurrent Infections  Yes  No  DK

Type of infection: \_\_\_\_\_

Kidney problems  Yes  No  DK

Night sweats  Yes  No  DK

Osteoporosis  Yes  No  DK

Persistent swollen glands  
in neck  Yes  No  DK

Severe headaches/  
migraines  Yes  No  DK

Severe or rapid weight loss  Yes  No  DK

Sexually transmitted disease  Yes  No  DK

Excessive urination  Yes  No  DK

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?  Yes  No  DK

Name of physician or dentist making recommendation: \_\_\_\_\_ Phone: *Include area code*  
( )

Do you have any disease, condition, or problem not listed above that you think I should know about?  Yes  No  DK  
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: \_\_\_\_\_

Signature of Dentist: \_\_\_\_\_ Date: \_\_\_\_\_

**FOR COMPLETION BY DENTIST**

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### **Dental Insurance Information**

Who is responsible for this account? \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_

Insurance Co: \_\_\_\_\_ Group#: \_\_\_\_\_

Birthdate: \_\_\_\_\_

SS/ID#: \_\_\_\_\_

Is patient covered by additional insurance? Yes \_\_\_ No \_\_\_

Relationship to Patient: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Insurance Co: \_\_\_\_\_

Group#: \_\_\_\_\_

### **Assignment and Release**

I certify that I, and/or my dependent(s), have insurance coverage with  
and assign directly to Dr. \_\_\_\_\_ all insurance benefits, if any, otherwise  
payable to me for services rendered. I understand that I am financially responsible for all charges whether  
paid by insurance or not. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the  
above-named insurance company(ies) and their agents for the purpose of obtaining payment for services  
and determining insurance benefits or the benefits payable for related services.

\_\_\_\_\_  
Signature of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Date

## Ronald A. Vitullo, D.D.S.

### OFFICE POLICIES

- **24 hour cancellation policy**: Any appointment cancelled with less than 24 hours notice will be subject to a cancellation fee. The fee will be \$1.00 per minute based on the length of the appointment scheduled.
- **Missed appointments**: Missed appointments are subject to the same charges described in the above cancellation policy. Three (3) missed (no show) appointments will result in dismissal from our care.
- **Late arrival**: As a courtesy to other patients, if you arrive more than fifteen minutes late for your appointment, we may need to reschedule your appointment.
- **Dental Insurance**: Your insurance coverage is a contract between you and/or your employer and the insurance company. **It is your responsibility to understand your insurance coverage.** We will verify insurance and prepare pretreatment estimates if requested. As a courtesy to our patients we will prepare and submit all necessary insurance forms for any treatment rendered. Our office will also accept assignment of your insurance benefits. It is important to note that verbal, faxed, or written pretreatment estimates from your insurance company are only estimates, and a final decision on coverage will only be determined by your insurance at the time of final claims submission and review. **Remaining balances after insurance has paid are the patient's responsibility.**
- **Financial arrangements**: If you have insurance, our insurance software will closely estimate your portion of the treatment costs. **It is our policy to collect your portion of the payment/co-payment when treatment is rendered.** For your convenience we accept cash, check, Mastercard, Visa, and Discover. We also have finance programs available.

**I agree that I have read and understand the foregoing Office Policies.**

**Patient Name:** \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_



**Authorization to Accept Financial Responsibility**

I, the undersigned, understand that my dental insurance company may reimburse posterior composite (white fillings) at the same amount that amalgam (silver) fillings are benefited for the same teeth.

It is understood, however, that often times it is the preference of the patient and/or the treating dentist to utilize composite materials. Under these circumstances, I accept the additional financial responsibility, if any, for the placement of posterior composites. My actual cost will be determined by deducting the insurance company's payment amount from the actual charge.

Print \_\_\_\_\_

\_\_\_\_\_

Patient signature/ parent/guardian if a minor

Date

# RONALD A. VITULLO, D.D.S.

\* You May Refuse to Sign This Acknowledgment\*

**I have read/received a copy of this office's Notice of Privacy Practices, and give Consent for the use and disclosure of Private Health Information as described therein.**

Print Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_

Signature: \_\_\_\_\_ DATE: \_\_\_\_\_

For Office Use Only

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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)

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## COMMUNICATION CONSENT FORM

We will not release confidential and/or other protected health information (PHI) by home mailing, home telephone, voice mail, work telephone, cell phone without consent.

I, \_\_\_\_\_ authorize office of Ronald A. Vitullo, DDS to contact me and/or a designated personal representative to convey PHI and/or appointment reminders by the following methods and assume responsibility to notify Ronald A. Vitullo, DDS office whenever this information changes:

	<u>PHI</u>	<u>PHONE</u>	<u>APPOINTMENT INFO</u>
Home Telephone	___YES ___NO # _____		___YES ___NO
Work Telephone	___YES ___NO # _____		___YES ___NO
Voice Mail	___YES ___NO # _____		___YES ___NO
Cell Phone	___YES ___NO # _____		___YES ___NO

Mailing Address \_\_\_\_\_

## PATIENT AUTHORIZATION FOR PERSONAL REPRESENTATIVE

**Purpose of Request:** I authorize the practice to disclose or provide my protected health information to the following individual(s) who is authorized to act as my personal representative for the purposes of receiving all protected health information about myself. As my designated personal representative, he/she may exercise my right to inspect, copy, and request amendments to my protected health information. My personal representative may also consent to, or authorize the use and/or disclosure of my protected health information:

**CHECK ALL THAT APPLY:**

     SPOUSE [NAME]: \_\_\_\_\_ PHONE: \_\_\_\_\_

     PARENT(s) [NAME(s)]: \_\_\_\_\_ PHONE: \_\_\_\_\_

     CHILD [NAME]: \_\_\_\_\_ PHONE: \_\_\_\_\_

     OTHER [NAME]: \_\_\_\_\_ PHONE: \_\_\_\_\_

- Description of information to be disclosed: I authorize the practice to disclose all of my protected health information to my designated personal representative.
- Expirations or termination of authorization: This authorization will remain in effect until terminated by you, your personal representative or another individual(s) of legal entity authorized to do so by court order or law.
- Right to revoke or terminate: As stated in our Notice of Privacy Practices, you have the right to revoke or terminate this authorization by submitting a written request.

**Disclosure:** We have no control over the person(s) you have listed as your personal representative; therefore, your protected health information disclosed under this authorization will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of this practice.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/ Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(Needed if individual is less than 18 years of age)