ADA American Dental Association
www.ada.org

Medical Alert:	Condition:	Premedication:	Allergies:	Anesthesia:	Date:

HEALTH HISTORY FORM

Name: (LAST FIRST MIDDLE) Home Phone: ( ) Business Phone: ( )

Address: (P.O. BOX or Mailing Address) City: State: Zip Code:

Occupation: Height: Weight: Date of Birth: Sex: M ❑ F ❑

SS#: Emergency Contact: Relationship: Phone: ( )

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

NAME RELATIONSHIP

For the following questions, please (X) whichever applies, your answers are for our records only and will be kept confidential in accordance with applicable laws. 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. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

DENTAL INFORMATION

	Yes	No	Don't Know
Do your gums bleed when you brush?	❑	❑	❑
Have you ever had orthodontic (braces) treatment?	❑	❑	❑
Are your teeth sensitive to cold, hot, sweets or pressure?	❑	❑	❑
Do you have earaches or neck pains?	❑	❑	❑
Have you had any periodontal (gum) treatments?	❑	❑	❑
Do you wear removable dental appliances?	❑	❑	❑
Have you had a serious/difficult problem associated with any previous dental treatment?	❑	❑	❑

If yes, explain:

How would you describe your current dental problem?

Date of your last dental exam:

Date of last dental x-rays:

What was done at that time?

How do you feel about the appearance of your teeth?

MEDICAL INFORMATION

If you answer yes to any of the 3 items below, please stop and return this form to the receptionist.

	Yes	No	Don't Know
Have you had any of the following diseases or problems?			
Active Tuberculosis	❑	❑	❑
Persistent cough greater than a 3 week duration	❑	❑	❑
Cough that produces blood	❑	❑	❑
Are you in good health?	❑	❑	❑
Has there been any change in your general health within the past year?	❑	❑	❑
Are you now under the care of a physician?	❑	❑	❑

If yes, what is/are the condition(s) being treated?

Date of last physical examination:

Physician:

NAME PHONE

ADDRESS CITY/STATE ZIP

NAME PHONE

ADDRESS CITY/STATE ZIP

	Yes	No	Don't Know
Have you had any serious illness, operation, or been hospitalized in the past 5 years?	❑	❑	❑

If yes, what was the illness or problem?

	Yes	No	Don't Know
Are you taking or have you recently taken any medicine(s) including non-prescription medicine?	❑	❑	❑

If yes, what medicine(s) are you taking?

Prescribed:

Over the counter:

Vitamins, natural or herbal preparations and/or diet supplements:

	Yes	No	Don't Know
Are you taking, or have you taken, any diet drugs such Pondimin (fenfluramine), Redux (dexphenfluramine) or phen-fen (fenfluramine-phentermine combination)?	❑	❑	❑
Do you drink alcoholic beverages?	❑	❑	❑

If yes, how much alcohol did you drink in the last 24 hours?

In the past week?

	Yes	No	Don't Know
Are you alcohol and/or drug dependent?	❑	❑	❑

If yes, have you received treatment? (circle one) Yes / No

	Yes	No	Don't Know
Do you use drugs or other substances for recreational purposes?	❑	❑	❑

If yes, please list:

Frequency of use (daily, weekly, etc.):

Number of years of recreational drug use:

	Yes	No	Don't Know
Do you use tobacco (smoking, snuff, chew)?	❑	❑	❑

If yes, how interested are you in stopping?
(circle one) Very / Somewhat / Not interested

	Yes	No	Don't Know
Do you wear contact lenses?	❑	❑	❑

PLEASE COMPLETE BOTH SIDES

Are you allergic to or have you had a reaction to?	Yes	No	Don't Know
Local anesthetics	❑	❑	❑
Aspirin	❑	❑	❑
Penicillin or other antibiotics	❑	❑	❑
Barbiturates, sedatives, or sleeping pills	❑	❑	❑
Sulfa drugs	❑	❑	❑
Codeine or other narcotics	❑	❑	❑
Latex	❑	❑	❑
Iodine	❑	❑	❑
Hay fever/seasonal	❑	❑	❑
Animals	❑	❑	❑
Food (specify) _____	❑	❑	❑
Other (specify) _____	❑	❑	❑
Metals (specify) _____	❑	❑	❑

To yes responses, specify type of reaction.

	Yes	No	Don't Know
Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	❑	❑	❑

If yes, when was this operation done?

If you answered yes to the above question, have you had any complications or difficulties with your prosthetic joint?

	Yes	No	Don't Know
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	❑	❑	❑

If yes, what antibiotic and dose?

Name of physician or dentist*:

Phone:

WOMEN ONLY

	Yes	No	Don't Know
Are you or could you be pregnant?	❑	❑	❑
Nursing?	❑	❑	❑
Taking birth control pills or hormonal replacement?	❑	❑	❑

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

	Yes	No	Don't Know
Abnormal bleeding	❑	❑	❑
AIDS or HIV infection	❑	❑	❑
Anemia	❑	❑	❑
Arthritis	❑	❑	❑
Rheumatoid arthritis	❑	❑	❑
Asthma	❑	❑	❑
Blood transfusion. If yes, date: _____	❑	❑	❑
Cancer/Chemotherapy/Radiation Treatment	❑	❑	❑
Cardiovascular disease. If yes, specify below:	❑	❑	❑

____ Angina
____ Arteriosclerosis
____ Artificial heart valves
____ Congenital heart defects
____ Congestive heart failure
____ Coronary artery disease
____ Damaged heart valves
____ Heart attack
____ Heart murmur
____ High blood pressure
____ Low blood pressure
____ Mitral valve prolapse
____ Pacemaker
____ Rheumatic heart disease/Rheumatic fever

Chest pain upon exertion	❑	❑	❑
Chronic pain	❑	❑	❑
Disease, drug, or radiation-induced immunosuppression	❑	❑	❑
Diabetes. If yes, specify below:	❑	❑	❑

____ Type I (Insulin dependent) ____ Type II

Dry Mouth	❑	❑	❑
Eating disorder. If yes, specify: _____	❑	❑	❑
Epilepsy	❑	❑	❑
Fainting spells or seizures	❑	❑	❑
Gastrointestinal disease	❑	❑	❑
G.E. Reflux/persistent heartburn	❑	❑	❑
Glaucoma	❑	❑	❑

	Yes	No	Don't Know
Hemophilia	❑	❑	❑
Hepatitis, jaundice or liver disease	❑	❑	❑
Recurrent Infections	❑	❑	❑
If yes, indicate type of infection: _____			
Kidney problems	❑	❑	❑
Mental health disorders. If yes, specify: _____	❑	❑	❑
Malnutrition	❑	❑	❑
Night sweats	❑	❑	❑
Neurological disorders. If yes, specify: _____	❑	❑	❑
Osteoporosis	❑	❑	❑
Persistent swollen glands in neck	❑	❑	❑
Respiratory problems. If yes, specify below:	❑	❑	❑

____ Emphysema ____ Bronchitis, etc.

Severe headaches/migraines	❑	❑	❑
Severe or rapid weight loss	❑	❑	❑
Sexually transmitted disease	❑	❑	❑
Sinus trouble	❑	❑	❑
Sleep disorder	❑	❑	❑
Sores or ulcers in the mouth	❑	❑	❑
Stroke	❑	❑	❑
Systemic lupus erythematosus	❑	❑	❑
Tuberculosis	❑	❑	❑
Thyroid problems	❑	❑	❑
Ulcers	❑	❑	❑
Excessive urination	❑	❑	❑
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. 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

Comments on patient interview concerning health history:

Significant findings from questionnaire or oral interview:

Dental management considerations:

Health History Update: On a regular basis the patient should be questioned about any medical history changes, date and comments notated, along with signature.

Date	Comments	Signature of patient and dentist

RESPONSIBILITY AND CONSENT STATEMENT

RI DENTAL,LTD
MEHRAN JAVID, D.M.D
1351 SOUTH COUNTY TRAIL #120
EAST GREENWICH, RI 02818

DATE_____

I hereby authorize and request the performance of dental services for myself or for:

_____ AGE_____
_____ AGE_____
_____ AGE_____

I also give my consent to any advisable and necessary dental procedures, medications, or anesthetics to be administered by the attending dentist, Dr. Mehran Javid, or by his supervised staff for diagnostic purposes or dental treatment.

I understand and acknowledge that I am financially responsible for the services provided to me or the above named patient under my care regardless of insurance coverage.

Pt. Name _____
Date _____

****<u>NOTICE</u>****

All deductibles and estimated co-payments are to be paid in full at the time of your visit.

All existing balances are to be paid in full before your next visit.

<u>Beginning September 17, 2007:</u>
Appointments broken without 24 hour notice will be charged a $50.00 fee, payable *before* a new appointment will be scheduled.

In the event that patient accounts are not paid in full within a reasonable amount of time, all collection costs, attorney fees and court expenses will be added to the patient's balance.

Signature:_____Date_____

MEHRAN JAVID, D.M.D
RI DENTAL, LTD

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgment

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
signature

_____
Date

****

**********For Office Use Only **********

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

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgment
- Other :
- _____
  _____
  _____

MEHRAN JAVID, DMD
RI DENTAL, LTD

HIPAA
NOTICE OF INFORMATION PRACTICES

1. *RI Dental, LTD.* may use and disclose protected health information for treatment, payment and healthcare operations. Examples of these include, but are not limited to, requested school or sports physicals; referrals to nursing homes, foster care homes, home health agencies; and/or other providers for treatment. Payment examples include, but are not limited to, insurance companies for claims, including coordination of benefits with other insurers or collections agencies. Healthcare operations include, but are not limited to, internal quality control and assurance, including auditing of records.

2. *RI Dental, LTD.* is permitted or required to use or disclose protected health information without patient written consent or authorization in certain circumstances. Two examples are public health requirements or court orders.

3. *RI Dental, LTD*. will not make any other use or disclosure of a patient's protected health information without the patient's written authorization. Such authorization may be revoked at any time. Revocation must be written.

4. *RI Dental, LTD*. may at times contact the patient to provide appointment reminders, information regarding treatment alternatives or other health-related benefits and services that may be of interest to the patient.

5. *RI Dental, LTD.* Will abide by the terms of this notice or the notice currently in effect at the time of the disclosure.

6. *RI Dental, LTD*. Reserves the right to change the terms of its notice and to make new notice provisions effective for all protected health information that it maintains.

7. ***RI Dental, LTD.*** Will provide each patient with a copy of any revisions to its Notice of Information Practices at the time of his/her next visit or at his/her last known address if there is a need to use or disclose any protected health information of the patient. Copies also may be obtained at any time from ***RI Dental, LTD.***

8. Any patient may file a complaint with ***RI Dental, LTD.*** And the Secretary of Health and Human Services if he/she believes that his/her privacy rights have been violated. To file a complaint with ***RI Dental, LTD.*** Please contact Privacy Officer at the following address and/or telephone number: (401) 541-9161.

   All complaints will be addressed, and the results will be reported to the Compliance Officer.

9. It is ***RI Dental, LTD***'s policy is that no retaliatory action will be taken against any patient who submits or conveys a complaint of suspected or actual noncompliance with the privacy standards.

10. The name, title and telephone number of the individual at ***RI Dental, LTD.*** to contact for further information is:

    Privacy Officer/Office Manager
    (401) 541-9161 fax (401) 541-9162
    email; www.drjavid.com

11. The effective date is April 14, 2003