MEDICAL HISTORY

Name

Address

City

State Zip

Phone: home: office: cell:

Soc.Sec.No.

Date of birth

Email Address

Name of physician

Address

City

State Zip

Date of last physical exam

In case of emergency notify

Phone Relationship

Do you have any history of:	**Yes**	**No**
Anemia		
Angina		
Arthritis		
Asthma		
Blood disease		
Blood pressure (high)		
Blood pressure (low)		
Blood transfusion		
Bruise easily		
Cancer		
Cardiac pacemaker		
Chemotherapy		
Chest pains		
Diabetes		
Easily winded		
Emphysema		
Epilepsy/Convulsions		
Excessive bleeding		
Fainting/Seizures		
Frequently tired		
Glaucoma		
Hay fever/Allergies		
Heart attack		
Heart disease		

Do you have any history of:	**Yes**	**No**
Heart murmur		
Heart trouble		
Heart valve problems		
Hepatitis/Jaundice		
HIV or AIDS		
Joint replacement or implant		
Kidney/Bladder trouble		
Leukemia		
Liver disease		
Lung disease		
Mental disorders		
Parkinson's Disease		
Prolonged bleeding		
Radiation treatment		
Recent weight loss		
Respiratory problems		
Rheumatic fever		
Sexually transmitted disease		
Sinus trouble		
Stomach troubles/Ulcers		
Stroke		
Swollen ankles		
Thyroid problems		
Tuberculosis		
Other		

	Yes	No
Are you under medical treatment now?		
Explain:		
Have you ever been hospitalized for any operation or serious illness?		
Explain:		
Do you drink alcohol?		
If yes: How much?		
Do you use cocaine or other drugs?		
Do you use tobacco?		
Are you wearing contact lenses?		

Are you allergic to or have you had any reactions to the following?	Yes	No
Local anesthetics (ex: novocaine)		
Penicillin or other antibiotics		
Sulfa Drugs		
Barbiturates		
Sedatives		
Iodine		
Aspirin		
Codeine		
Other		

Check any of the following that you are taking or have taken:

____ Cortisone drugs/steroids _____ Anticoagulants/blood thinners _____Tranquilizers/sedatives

Check if you have ever been given:

_____ Novocaine _____ Penicillin _____ Erythromycin _____ Codeine _____ Fluoride supplement/rinse

List any medications you are taking _____

Women only:	***Yes***	***No***
Are you or think you may be pregnant?		
If yes : How many months		
Are you breast feeding?		

	Yes	No
Are you taking any hormone therapy?		
Are you taking any birth control pills/shots?		

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of patient or parent if minor *Date*

Doctor's signature *Date*

Comments

Dental Questionnaire

Last **First** **Middle** **Nickname**

Correct answers to the following questions will allow the dentist to treat you on a more individual basis, providing the care appropriate for your particular needs. Your answers are for our records only and will be considered confidential.

1. Are you having any discomfort at this time? Yes___ No___
2. Have you ever had any serious trouble associated with previous dentistry? Yes___ No___
3. Does dental treatment make you nervous? No___ Slightly___ Moderately___ Extremely___
4. Date of last dental visit?_____
5. Have you ever been treated for periodontal disease? (gum disease,pyorrhea,trench mouth) Yes___No___
6. How often do you brush ?_____ Brush is: Soft_____ Medium_____ Hard_____
7. Do you have or have you ever had any of the following:

MOUTH		**TEETH**	
Bleeding, sore gums	Yes___No___	Loose teeth	Yes___No___
Unpleasant taste/bad breath	Yes___No___	Sensitive to hot	Yes___No___
Burning tongue/lips	Yes___No___	Sensitive to cold	Yes___No___
Frequent blister,lips/mouth	Yes___No___	Sensitive to sweets	Yes___No___
Swelling lumps in mouth	Yes___No___	Sensitive to biting	Yes___No___
Ortho treatments (braces)	Yes___No___	Food impaction	Yes___No___
Biting cheeks/lips	Yes___No___	Clenching/grinding	Yes___No___
Clicking/popping jaw	Yes___No___	If so, when_____	
Difficulty opening or closing jaw	Yes___No___	Shifting of bite	Yes___No___
		Change in bite	Yes___No___

8. Do you use the following?
   Brush Yes___No___ Dental floss Yes___No___ Flouride rinse Yes___No___
   Other_____

These are the things that are important to me about my dental health:_____

_____

What do you fear most about dental care?_____

CIRCLE ONE:

1. My mouth is a. very comfortable b. moderately comfortable c. uncomfortable
2. I a. think the appearance of my mouth is excellent b. am satisfied with the appearance of my mouth c. am dissatisfied with the appearance of my mouth
3. I a. will do anything to keep my natural teeth b. want to keep my teeth, but have a certain budget of time and money to spend on them
4. I a. have set goals for my oral health with a previous dentist b. want to set goals concerning my dental health
5. I a. have always done the best that was recommended for my dental health b. have not done what dentists have recommended to me c. rarely go, and don't care much about having dental work completed
6. I a. have put dentistry for myself and family high on my priority list b. put dentistry for myself and my family low on my priority list c. dentistry is on my list but it's hard to find
7. I think my present state of dental health is a. excellent b. good c.poor

What are some questions about dentistry and oral health that you have never had adequately answered?

_____

_____

RESPONSIBLE PARTY

NAME_____ RELATIONSHIP TO PATIENT _____

ADDRESS_____ HOME PHONE _____
EMPLOYER_____ WORK PHONE _____

DENTAL INSURANCE INFORMATION

NAME OF INSURED _____ RELATIONSHIP TO PATIENT_____

BIRTHDATE_____ SOC. SEC # _____ HOME PHONE _____

ADDRESS _____CITY_____ STATE _____ZIP _____

NAME OF EMPLOYER _____ WORK PHONE _____

ADDRESS OF EMPLOYER _____CITY_____STATE____ZIP_____

INSURANCE CO._____GROUP #_____ UNION OR LOCAL_____

INSURANCE CO. ADDRESS_____CITY_____STATE____ZIP_____

*If you have additional insurance, please complete the following:

NAME OF INSURED_____RELATIONSHIP TO PATIENT _____

BIRTHDATE_____SOC. SEC. #_____HOME PHONE _____

ADDRESS_____CITY_____STATE_____ZIP_____

_

NAME OF EMPLOYER_____ WORK PHONE_____

ADDRESS OF EMPLOYER_____ CITY _____STATE_____ZIP _____

INSURANCE CO._____GROUP#_____ UNION OR LOCAL_____

INSURANCE CO. ADDRESS_____CITY_____STATE _____ ZIP_____

INSURANCE AUTHORIZATION – SIGNATURE ON FILE

I hereby authorize my health care provider to affix my name to all insurance submissions, documents, and/or information requested by my insurance company (s) relating to any and all health benefits due to me and my dependents.
I also authorize payment of healthcare benefits otherwise payable to me, directly to my doctor as listed above. I agree to be held responsible for all charges and services not paid by my insurance company.

_____ _____
Today's Date Signature of Patient or Insured

Our Financial Policy

We are committed to providing you with the best dental care and the finest service possible. In order to maintain these high standards, we must receive prompt payment.

As a service to our patients, who are covered by dental insurance, we will be happy to fill out and submit your insurance reimbursement forms directly to your insurance carrier. This does not relieve you of your responsibility for any charges that are not reimbursed by your insurance carrier**. We accept cash, personal checks, MasterCard or Visa.**

In the event that you should need an extended payment plan, we will be happy to arrange one for you through the **CITI HEALTH** program.

In order to maintain our high standards of service, we must insist on payment in full within 60 days of service. Should you have any problems complying with these terms, kindly contact our office to make other arrangements. Should your balance extend beyond 60 days, without special arrangements having been made in advance, a **monthly 1.3% finance charge will accrue.**

Should your account become delinquent, any expenses that we incur during the collection process will be your responsibility, and as such will be added to your account. You agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 33% of the debt, and all costs, and expenses, including reasonable attorneys' fees, we incur in such collection efforts.

Please call us if you have any questions or concerns regarding our policies at 469-7722.

_____ _____

Signature Date

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW DENTAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your dentist, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the dentist's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your healthcare with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a dentist to whom you have been referred to ensure that the dentist has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your dentist's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your dentist. We may also call you by name in the waiting room when your dentist is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by Law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors, and Organ Donation, Research, Criminal Activity, Military Activity and National Security, Workers' Compensation, Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization at any time, in writing, except to the extent that your dentist or the dentist's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your dentist is not required to agree to a restriction that you may request. If dentist believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional. .

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your dentist amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint**.

This notice was published and becomes effective on/or before **April 14, 2003**.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.
Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: _____

Signature _____ Date _____

Randal P. Swartwood, D.D.S.

4834 West Seneca Turnpike

Syracuse, NY 13215

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse To Sign This Acknowledgement****

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 acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

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

Randal P. Swartwood, D.D.S.
4834 West Seneca Turnpike
Syracuse, NY 13215
315-469-7722

Dear Dr. _____,

I, _____, am requesting my and/or family dental records (including any recent x-rays) be sent to:

Randal P. Swartwood, D.D.S.

4834 West Seneca Turnpike

Syracuse, New York 13215

Signed _____

Date _____