Name

Cell #

Residence Address | Residence Telephone No. | Business Address | Card No. | Business Telephone No.

City | Send Statement to

1 Date	2 Services Rendered	3 Fee Charged	4 Credits and Discounts	5 Balance
	BALANCE BROUGHT FORWARD			
	BALANCE CARRIED FORWARD			

1 Date	2 Services Rendered	3 Fee Charged	4 Credits and Discounts	5 Balance
	BALANCE BROUGHT FORWARD			
	BALANCE CARRIED FORWARD			

SHOW A CREDIT BALANCE IN RED

FORM 20082

(01/04)

SSH

HEALTH QUESTIONNAIRE

Name ______________________ Birth date ______________________

Correct answers to the following questions will allow your dentist to treat you on a more individual basis, providing the care appropriate for your particular needs. Circle yes or no, whichever applies, in response to the following questions. Your answers are for our records only and will be considered confidential.

DENTAL

1. Are you having any discomfort at this time .... Yes No
2. Have you ever had any serious trouble associated with previous dental treatment? .... Yes No
   If so explain? ______________________
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
   If so when? ______________________
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

Bleeding, sore gums	Yes	No
Unpleasant taste/bad breath	Yes	No
Burning tongue/lips	Yes	No
Frequent blisters, lip/mouth	Yes	No
Swelling/lumps in mouth	Yes	No
Ortho treatments (braces)	Yes	No
Biting cheeks/lips	Yes	No
Clicking/popping jaw	Yes	No
Difficulty opening or closing jaw	Yes	No

TEETH

Loose teeth	Yes	No
Sensitive to hot	Yes	No
Sensitive to cold	Yes	No
Sensitive to sweets	Yes	No
Sensitive to biting	Yes	No
Food impaction	Yes	No
Clenching/grinding	Yes	No
If so, when ______		
Shifting in bite	Yes	No
Change in bite	Yes	No

8. Do you use the following?

Brush	Yes	No
Dental floss	Yes	No
Fluoride rinse	Yes	No
Other ______		

MEDICAL

1. Has there been any change in your general health within the past year .... Yes No
2. My last physical examination was on ______________________
3. Are you now under the care of a physician .... Yes No
   If so, what is the condition being treated ______________________
4. The name and address of my physician is ______________________
   ____
5. Have you had any serious illness within the past five (5) years .... Yes No
   If so, what was the illness ______________________
6. Have you been hospitalized or had an operation within the past five (5) years .... Yes No
   If so, what was the problem ______________________
7. Do you have or have you had any of the following diseases or problems
   - a. Rheumatic fever or rheumatic heart disease .... Yes No
   - b. Congenital heart disease .... Yes No
   - c. Cardiovascular disease (heart trouble, heart attack, heart murmur, coronary insufficiency, coronary occlusion, high/low blood pressure, arteriosclerosis, stroke, etc.) .... Yes No
     - 1) Do you have pain in chest upon exertion .... Yes No
     - 2) Are you ever short of breath after mild exercise .... Yes No
     - 3) Do your ankles swell .... Yes No
     - 4) Do you get short of breath when you lie down, or do you require extra pillows when you sleep .... Yes No
   - d. Artificial or replacement valves .... Yes No
   - e. Pacemaker .... Yes No
   - f. Allergy .... Yes No
   - g. Sinus trouble .... Yes No
   - h. Asthma or hay fever .... Yes No
   - i. Hives or a skin rash .... Yes No
   - j. Fainting spells or seizures .... Yes No
   - k. Diabetes .... Yes No
     - 1) Do you have to urinate (pass water) more than six times a day .... Yes No
     - 2) Are you thirsty much of the time .... Yes No
     - 3) Does your mouth frequently become dry .... Yes No

l. Hepatitis, jaundice or liver disease .... Yes No
m. Arthritis or inflammatory rheumatism .... Yes No
n. Artificial or replacement joints, prosthetic .... Yes No
o. Digestive system—Ulcers or stomach disorders (colitis) .... Yes No
p. Kidney trouble .... Yes No
q. Tuberculosis .... Yes No
r. Persistent cough or cough up blood .... Yes No
s. Immune System disorders (including AIDS, HIV, ARC) .... Yes No
t. Venereal disease .... Yes No
u. Other ____________

8. Have you had abnormal bleeding associated with previous extractions, surgery or trauma? .... Yes No
   a. Do you bruise easily .... Yes No
   b. Have you ever required a blood transfusion .... Yes No
      If so, explain the circumstances & when ____________
9. Have you ever tested positive for the AIDS virus? .... Yes No
10. Do you have any blood disorder such as anemia? .... Yes No
11. Have you had surgery or x-ray treatment for a tumor, growth, or other condition? .... Yes No
12. Are you taking any of the following:
   a. Antibiotics or sulfa drugs .... Yes No
   b. Anticoagulants (blood thinners) .... Yes No
   c. Medicine for high blood pressure .... Yes No
   d. Cortisone (steroids) .... Yes No
   e. Tranquilizers .... Yes No
   f. Antihistamines .... Yes No
   g. Aspirin .... Yes No
   h. Insulin, tolbutamide (Orinase) or similar drug for diabetes .... Yes No
   i. Digitalis or drugs for heart trouble .... Yes No
   j. Nitroglycerin .... Yes No
   k. Other medications .... Yes No
   l. If "Yes" to any of the above, state drug name, dosage and frequency ____________
13. Are you allergic or have you reacted adversely to:
   a. Local anesthetics .... Yes No
   b. Penicillin or other antibiotics .... Yes No
   c. Sulfa drugs .... Yes No
   d. Barbiturates, sedatives, or sleeping pills .... Yes No
   e. Aspirin .... Yes No
   f. Iodine .... Yes No
   g. Codeine or other narcotics .... Yes No
   h. Other ____________
14. Do you use any tobacco products .... Yes No
    If so, how much per day and what ____________
15. Do you use any alcohol products .... Yes No
    If so, how much per day/week/month and what ____________
16. Do you use any caffeinated products (coffee, tea, chocolate, etc.) .... Yes No
    If so, how much per day and what ____________
17. Do you have any disease, condition, or problem not listed above that you think I should know about? .... Yes No
    If so, explain ____________

    ____
18. Are you employed in any situation which exposes you regularly to x-rays or other ionizing radiation .... Yes No
19. Are you wearing contact lenses .... Yes No
20. Are you experiencing stress or pressure in your work or at home .... Yes No

WOMEN

20. Are you pregnant .... Yes No
21. Do you have PMS or problems associated with your menstrual period .... Yes No
22. Are you taking birth control or hormone therapy .... Yes No

Remarks:

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health or change in my medication, I will inform the dentist at the next appointment.

____________ ____________

Signature of Patient   Date   Signature of Dentist   Date

INSURANCE AND CONSENT OF TREATMENT

Patient Name:

Name of Primary Insurer:________________Primary Insurer DOB:_______

Primary Insurer SS# :________________Insurance Co. ____________Group # ______

Insurance Company Address:____

Do you have duel coverage: Yes or No

Name of Secondary Insurer:________________Secondary Insurer DOB :_______

Secondary Insurer SS# :______________Insurance Co. __________ Group # __________

Insurance Company Address :____

Consent:

1. The undersigned hereby authorizes Camillo Rispoli DDS to order x-rays, models, photographs, or any diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patients dental needs.

2. I authorize Camillo Rispoli DDS to perform all recommened treatment manually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with ______________________. I understand that using anesthetic agents emodies a certain risk. Furthermore, I authorize and consent that Camillo Rispoli DDS choose and employ such assistance as deemed fit to provide recommended treatment.

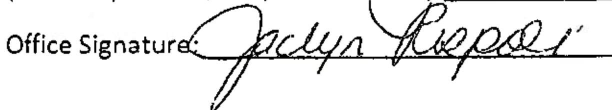
3. I understand that any cost quoted to me on the day of my visit is only an estimate and is not a guarantee that insuranace will cover the balance. I understand that all responsibility for payment of dental services provided in this office for myself or my dependents is mine and due payable at time services are rendered. In the event payments are not received by agreed upon date I understand that a monthly 1.5% finance charge will be added to my account. I understand that when necessary credit burea reports will be obtained and I am responsible for all collection cost that are incurred.

4. I understand that it is my responsibility to advise your office of any changes in the information obtained on this form.

Patient Signature:____________________________ Date:________________

(If Minor) Parent/Responsible Party:________________ Relationship to Patient:___________

Office Signature:



ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES / USE AND DISCLOSURE FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. We provide this form to comply with the Health Insurance Portability and Accountability Act (HIPAA). Please review the Notice of Privacy Practices thoroughly before signing this acknowledgement form. If terms of our Notice change, a revised copy will be made available to you.

By signing this form, you acknowledge that our practice may use and disclose PHI about you for treatment, payment and healthcare operations. You have the right to request that we restrict how PHI about you is used or disclosed for treatment, payment or healthcare operations.

_______________________________   ____________ / / ____
Signature of Patient or Legal Representative   Date

_______________________________   _______________________________
Printed Name of Patient   Legal Relationship to the Patient *(If required)*

We cannot discuss your health information with anyone other than yourself unless you authorize us to do so. Please list below names of the individuals you authorize our office to discuss care with.

I give you permission to share my health information with:

1. Name ______________________ Relationship ____________ Phone____________
2. Name ______________________ Relationship ____________ Phone____________

Consent to email or text for appointment reminders and other healthcare communication.

If you approve, we may contact you via email and/or text messaging to remind you of an appointment or provide general health reminders or information. I understand that once I have consented to receive communications via text or email, I still have the right to revoke the consent at any time.

The cell phone number I authorize to receive text messages for appointment reminders and general health information is ______________________. Please initial ________.

The email address that I authorize to receive email messages for appointment reminders and general health information is ______________________. Please initial ________.

Or

_________ **I decline** to receive communications via text.

_________ **I decline** to receive communications via email.

Revocation – Use this area to document revocation of a previous form of communication.

_____ I hereby revoke my request to receive future appointment reminders or healthcare updates via text.
_____ I hereby revoke my request to receive future appointment reminders or healthcare updates via email.

Patient signature______________________________ Date requested: ______________

Reminder - Keep information to the minimum necessary and encrypt emails and texts whenever possible

HIPAA Acknowledgement of Receipt of the Notice of Privacy Practices

This form does not constitute legal advice and covers only federal, not state, law.