

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: | | | Home Phone: <i>Include area code</i> | Business/Cell Phone: <i>Include area code</i> |
| <i>Last</i> | <i>First</i> | <i>Middle</i> | () | () |
| Address: | | | City: | State: Zip: |
| <i>Mailing address</i> | | | | |
| 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> | |
| Do you have any of the following diseases or problems: | <i>(Check DK if you Don't Know the answer to the the question)</i> | Yes No DK |
| Active Tuberculosis..... | | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| Persistent cough greater than a 3 week duration..... | | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| Cough that produces blood..... | | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| Been exposed to anyone with tuberculosis..... | | <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

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

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

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: _____

Post Operative Instructions after a Tooth Extraction

Drs. Palma, Nardozza, McKevitt, and Wenman

The removal of a tooth is a surgical procedure. The recovery process, in most cases, can last a few days. To allow for optimum comfort and healing, please be sure to read and follow all instructions.

1. Bite gently on the gauze pad placed over the extraction site. Applying pressure for a minimum of 30 minutes will aid in clot formation. If bleeding is still present after 30 minutes, be sure to replace gauze and continue to apply pressure. Pressure on a wet tea bag can also aid in clot formation if bleeding persists. If you still have bleeding 24 hours after your surgery, please call your dentist.
2. Take your prescribed medication as soon as you begin to experience discomfort. If no medication has been prescribed to you, Advil, Naproxen or Tylenol can assist with pain relief.
3. Refrain from smoking for a minimum of 72 hours. Smoking can inhibit and prolong the healing process.
4. Abstain from spitting, drinking through straws, and rinsing vigorously for a minimum of 24 hours. Engaging in such activities can cause the healing clot to be dislodged.
5. After 24 hours has passed, begin rinsing with warm salt water rinses 2-3 times per day to cleanse and heal the surgical site. An appropriate salt water solution consists of 1 teaspoon salt to an 8 ounce glass of warm water.
6. Swelling is a common occurrence after a tooth extraction. The amount of swelling depends on the type and difficulty of the extraction. You can minimize the swelling by applying an ice pack to the affected area. For the first three hours, alternate the ice pack on for 10 minutes and off for 10 minutes.
7. If sutures were required following your extraction, it may not be necessary to return to have the sutures removed unless instructed by your dentist. If dissolvable sutures were placed, they can take up to 2 weeks to dissolve.
8. For any additional questions or concerns, please do not hesitate to contact the office at 468-1000 or 488-2911.

Palma and Nardoza, DDS PC

NOTICE OF PRIVACY PRACTICES

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.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.**

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 4/14/03, 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. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available 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.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

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

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

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 of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you \$0.75 for each page, \$15 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format; if you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: DR. V.S. NARDOZZA

Telephone: 315-488-2911

Fax: 315-468-1696

E-mail: _____

Address: 523 Charles Ave.

SOLVAY, N.Y. 13209

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This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).

Palma and Nardoza, DDS PC

**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
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

This signed document grants Palma and Nardozza, DDS PC, to share pertinent health information of a patient with the designated person(s) listed below:

Patient: _____

Address: _____

Above patient grants permission to share health information to:

Name: _____ Relationship _____

Name: _____ Relationship _____

Name: _____ Relationship _____

Patient Signature: _____ Date _____

Revocation of Consent:

Patient Signature: _____ Date _____