MEDICAL HISTORY FORM

Date_____

Name_____ Home Phone_____

Last First Middle Business Phone_____

Email Address_____ Cell Phone_____

Address_____ Apt____ City_____ State____ Zip_____

Occupation_____ Social Security Number_____

Date of Birth_____ Sex M F Single___Married___Divorced___Widowed___

Name of Spouse_____ Closest Relative_____ Phone_____

Referred by_____

Physician_____ Office Phone Number_____ Date of Last Exam_____

Physician Address_____

1. Are you in good health? ..... Y N
2. Are you under medical treatment now? ..... Y N
   If so, what is the condition being treated?_____
3. Have you had any serious illness, operation or been hospitalized in the past 5 years? Y N

   If so, please explain_____
4. Do you use cigarettes/chewing tobacco/cigars? ..... Y N
5. Do you use controlled substances? ..... Y N
6. Are you wearing contact lenses? ..... Y N
7. Do you have or have you had any of the following?

Abnormal Bleeding	Y	N	Glaucoma	Y	N	Mitral Valve Prolapse	Y	N
AIDS or HIV Infection	Y	N	Hay Fever	Y	N	Psychiatric Care	Y	N
Allergy	Y	N	Heart Attack	Y	N	Radiation Therapy	Y	N
Anemia	Y	N	Heart Defect (Inborn)	Y	N	Recent Weight Loss	Y	N
Angina	Y	N	Heart Disease	Y	N	Respiratory Problems	Y	N
Asthma	Y	N	Heart Murmur	Y	N	Rheumatic Fever	Y	N
Arthritis	Y	N	Heart Trouble	Y	N	Sexually Transmitted Disease	Y	N
Blood Transfusion	Y	N	Hepatitis/Jaundice	Y	N	Sinus Trouble	Y	N
Cancer	Y	N	High Blood Pressure	Y	N	Stomach Troubles/Ulcers	Y	N
Cardiac Pacemaker	Y	N	Joint Replacement/Implant	Y	N	Stroke	Y	N
Chest Pains	Y	N	Kidney Diseases	Y	N	Swollen Ankles	Y	N
Diabetes	Y	N	Leukemia	Y	N	Thyroid Problem	Y	N
Emphysema	Y	N	Liver Disease	Y	N	Tuberculosis	Y	N
Epilepsy/Convulsions	Y	N	Low Blood Pressure	Y	N	Tumor/Growth	Y	N

8. Do you have any disease, condition or problem not listed above that I should know about? ..... Y N

   If yes, please explain_____

9. Are you **allergic** or have you had any reactions to the following?

Any Metals (eg nickel, mercury)	Y	N	Iodine	Y	N	Penicillin/antibiotics	Y	N
Aspirin	Y	N	Latex/Rubber	Y	N	Sleeping Pills	Y	N
Barbituates/Sedatives	Y	N	Local Anesthetic (eg Novocain)	Y	N	Sulfa Drugs	Y	N
Codeine	Y	N	Narcotics	Y	N	Other	Y	N

10. Are you taking any medicine(s) including non-prescription medicine? ..... Y N

Aspirin	Y	N	Cholesterol	Y	N	Insulin/diabetic pills	Y	N
Antibiotics	Y	N	Fosamax, Actonel, Boniva	Y	N	Pain medicine	Y	N
Antidepressants	Y	N	Herbal Medicine(s)	Y	N	Vitamins	Y	N
Blood Thinner	Y	N	High Blood Pressure/Water Pill	Y	N	Other	Y	N

Name of the medicine(s) you are taking?_____

11. **Women Only:**

Are you pregnant?	Y	N	Are you nursing?	Y	N	Oral Contraceptives?	Y	N

PATIENT DENTAL HISTORY

Name of Previous Dentist and Location_____ Date of Last Exam_____

Chief Dental Complaint_____

Do you need antibiotic pre-medication?	Y	N	Do you have frequent headaches?	Y	N
Do your gums bleed while brushing/flossing?	Y	N	Do you clench or grind your teeth?	Y	N
Are you teeth sensitive to hot/cold liquids/foods?	Y	N	Do you bite your lips/cheeks frequently?	Y	N
Are your teeth sensitive to sweet/sour liquids/foods?	Y	N	Have you ever had any difficult extractions?	Y	N
Do you feel pain to any of your teeth?	Y	N	Have you ever had prolonged bleeding after extractions?	Y	N
Do you have any sores/lumps in your mouth?	Y	N	Have you had any orthodontic treatment?	Y	N
Have you had any head, neck or jaw injuries?	Y	N	Do you wear any removable denture appliance?	Y	N
Have you ever had TMJ clicking/pain?	Y	N	If yes, date of placement_____		
Have you ever had difficulty opening or closing jaw?	Y	N	Do you like your smile?	Y	N
Have you ever had difficulty chewing?	Y	N	If no, please explain_____		

AUTHORIZATION

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 and it is my responsibility to inform this office of any changes to the information I have provided. I authorize the staff to perform any necessary services needed during diagnosis and treatment. If account is not paid within 90 days of the date of service, and no financial arrangements have been made, I will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting my account.

_____

Signature or patient (or parent/guardian if minor)

INSURANCE AUTHORIZATION AND RELEASE

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____

Signature or patient (or parent/guardian if minor)

For completion by the dentist.

Comments on patient interview concerning medical history:_____

Significant findings from questionnaire or oral interview:_____

Dental management considerations:_____

_____ _____

Date *Signature of Dentist*

MEDICAL HISTORY UPDATE:

Date	Comments	Patient Signature	DDS Initial

Peter C. L. Teng, D.D.S.
Winifred Teng, D.D.S.
Michael Teng, D.D.S.
1021 Park Avenue
New York, NY 10028
(212) 289-5613

PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality, assessments and physicians certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this office has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this office at any time at the address below to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name (Please Print): _____

Patient Signature: _____

Relationship to Patient: _____

Date: _____