

**HEALTH HISTORY
(PLEASE COMPLETE IN INK)**

Patient's Name: _____

How do you prefer to be addressed? _____

Answers to the following questions are for our records only and will be considered confidential.

Circle One

- | | | | | |
|--|----------------|------------------|-------|---------------|
| 1. Date of Last Physical Examination | ____/____/____ | Physician's Name | _____ | |
| 2. Date of Last Dental Examination | ____/____/____ | Dentist's Name | _____ | |
| 3. Date of Last Dental X-Rays | ____/____/____ | | | |
| 4. Are you having pain or discomfort at this time? | _____ | | | YES NO |
| 5. Do you feel very nervous about having dental treatment? | _____ | | | YES NO |
| 6. Have you ever had a bad experience in the dental office? | _____ | | | YES NO |
| 7. Is there anything that you dislike about your smile? | _____ | | | YES NO |
| 8. Have you been a patient in the hospital during the past two years? What for? | _____ | | | YES NO |
| 9. Have you been under the care of a medical doctor during the past two years? What for? | _____ | | | YES NO |
| 10. List any medicines /drugs taken in the past two years and what for? | _____ | | | |
| 11. List all current medicines and what for? | _____ | | | |

12. Are you allergic to (i.e., itching, rash, swelling of hands, feet or eyes, or made sick) penicillin, aspirin, codeine, any drugs, medications, metals, or latex? _____ **YES NO**
If yes, please list: _____

13. Have you ever had any excessive bleeding requiring special treatment? _____ **YES NO**

14. Circle any of the following which you have had or have at present:
- | | | | |
|----------------------------|---------------------------------|--------------------------|---|
| Heart Failure | Psychiatric Treatment | Glaucoma | Fainting or Dizzy Spells |
| Heart Disease or Attack | Emphysema | Pain in Jaw Joints | ★ Any type of Implant (Heart Valve, etc.) |
| Angina Pectoris | Cough | Birth Defects | Sickle Cell Disease |
| High Blood Pressure | Tuberculosis (TB) | HIV Positive, ARC, AIDS | Bruise Easily |
| ★ Heart Murmur | Asthma | Hepatitis A (infectious) | ★ Artificial Hip, Knee or other joint |
| Rheumatic Fever | Hay Fever | Hepatitis B (serum) | MRSA |
| ★ Congenital Heart Lesions | Sinus Trouble | Hepatitis C | |
| Use of Tobacco Products | Allergies or Hives | Liver Disease | |
| Thyroid Disease | Diabetes | Jaundice | |
| Heart Pacemaker | Sexually Transmitted Diseases | Blood Transfusion | |
| Heart Surgery | Radiation Therapy | Drug Addiction | |
| Cancer (Type _____) | Chemotherapy (Cancer, Leukemia) | Hemophilia | |
| Anemia | Arthritis | ★ Any type of transplant | ARE YOU PRESENTLY |
| Stroke | Alcoholism | Cold Sores | TAKING A BLOOD |
| Kidney Trouble | Rheumatism | Herpes | THINNER? YES NO |
| Ulcers | Cortisone Medicine | Epilepsy or Seizures | |

★Antibiotic premedication may be required prior to your appointment.

- | | | |
|--|-------|---------------|
| 15. Are you taking any herbal medications? | _____ | YES NO |
| 16. Are there any growths or sores in or around your mouth? | _____ | YES NO |
| 17. Do you have any trouble chewing? | _____ | YES NO |
| 18. Does food catch between your teeth? | _____ | YES NO |
| 19. Do you have pain in or near your ears? | _____ | YES NO |
| 20. Do you habitually clench or grind your teeth during the day or night? | _____ | YES NO |
| 21. Have you ever been told that you have gum problems? | _____ | YES NO |
| 22. Do you now have bleeding gums or any other gum condition? | _____ | YES NO |
| 23. Do you have a family history of Gum Disease? | _____ | YES NO |
| 24. WOMEN: Are you pregnant now? | _____ | YES NO |
| 25. Is there anything related to your medical or dental history that you have not indicated above? | _____ | YES NO |
- If yes, explain: _____

I hereby authorize Dr. Dina L. Nuhfer and staff to perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page is correct to the best of my knowledge. I authorize release of any information relating to treatment. I understand that I am responsible for all costs of dental treatment.

SIGNATURE: _____ **Date:** _____

PATIENT INFORMATION

Name: _____ Home Phone: () _____
 Address: _____ Work Phone: () _____
 _____ Cell Phone: () _____
 City: _____ State: _____ Zip: _____ Employer: _____
 Social Security #: _____ Birth Date: / / Age: _____
 Sex: Male Marital Status: Single Married Widowed
 Female Divorced Separated
 E-mail Address: _____
 Would you like us to confirm your appointments by e-mail? YES NO
 Family Physician: _____ Physician's Phone: _____

Who can we thank for referring you? Please Check One. Patient: _____
 North East News Journal Facebook Google Reviews Other: _____

GUARANTOR / RESPONSIBLE PARTY INFORMATION

Name: _____ Home Phone: () _____
 Address: _____ Work Phone: () _____
 _____ Cell Phone: () _____
 City: _____ State: _____ Zip: _____ Employer: _____
 Guarantor's S.S. #: _____ Guarantor's Birth Date: / /

PRIMARY DENTAL INSURANCE

Insurance Co.: _____
 Name of Insured: _____
 Insured's Date of Birth: _____
 Insurance Address: _____
 City: _____ State: _____ Zip: _____
 Insurance Phone: () _____
 Policy/ID #: _____
 Group #: _____
 Employer Paid Plan? Yes No
 Relationship of Patient to Insured:
 Self Spouse Child Other

SECONDARY DENTAL INSURANCE

Insurance Co.: _____
 Name of Insured: _____
 Insured's Date of Birth: _____
 Insurance Address: _____
 City: _____ State: _____ Zip: _____
 Insurance Phone: () _____
 Policy/ID #: _____
 Group #: _____
 Employer Paid Plan? Yes No
 Relationship of Patient to Insured:
 Self Spouse Child Other

To the best of my knowledge, the questions on this form have been accurately answered. I authorize the dentist to release any information including the diagnosis and the records of any treatment and examination rendered to my dependents or me during the period of such dental care to third party payers and/or other 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 of Patient or Parent if minor

 Date

North East Dental Arts
**CONSENT FOR USE AND DISCLOSURE OF
HEALTH INFORMATION**

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ Social Security #: _____

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practice, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Alicia Rollinger
Address: 90 East Main Street, North East, PA 16428
Telephone: (814) 725-4700 **Fax:** (814) 725-3953

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we receive your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ **Date:** _____

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____ **Relationship to Patient:** _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT. SEE OTHER SIDE →

North East Dental Arts

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) _____

Comments: _____



Cancellation and Broken Appointment Policy

We understand that illness, emergencies, flat tires and bad weather do occur. We ask our patients to give us 48 hours notice whenever possible, if they cannot keep an appointment. This allows us time to fill our schedule with other patients who may be waiting.

Our number one concern is our patient's dental health. Providing services in a timely manner is critical to accomplish that goal. Our other goal is to keep the cost of dental services as economical as possible. The appointment you schedule for treatment is reserved for you and your treatment only. When you fail to keep your appointment without providing us adequate notice, this adds to the overall cost of care, as trained professionals and dental facilities are not being utilized.

We appreciate your understanding and consideration regarding our appointment policy and if you have any questions or concerns, please ask us.

Policy and Fees:

Cancellation or rescheduling of an appointment *with 48 hours or more notification* – No Charge

Cancellation or rescheduling of an appointment *with less than 48 hours and up to 24 hours* may or may not be considered a broken appointment; it will be our discretion.

Cancellation or rescheduling of an appointment with less than 24 hours notice is considered a **Broken Appointment** and will be charged a fee of:

\$40 for a hygiene appointment

\$75 for a doctor's appointment scheduled for one hour or less, each additional hour incurs an additional fee of **\$50**

A **broken appointment** is when you

- Cancel or Reschedule an appointment with less than 24 hours notice
- Do not show up for the scheduled appointment

I have read and understand the above mentioned policy.

Patient's Signature (Parent/Guardian if minor)

Today's Date

90 East Main Street North East, PA 16428
Phone – 814-725-4700 www.NorthEastDentalArts.com



Smile Analysis

Please circle Yes or No

Yes No Are your lower six front teeth straight?

Yes No Do you have any gaps or spaces between your teeth?

Yes No Are any of your teeth turned, crooked or uneven?

Yes No When you bite your front teeth (biting a sandwich) do all the front teeth come in contact?

Yes No Are the Upper front teeth straight? (versus being crooked, overlapped, Or protruding)

Yes No When you bite down with your back teeth (when you swallow), do all the Front teeth come in contact?

Yes No Do you usually smile with your mouth closed for pictures?

Yes No Do you want to change anything about your teeth?

Yes No Would you like to change anything about the appearance of your smile or teeth.

Yes No Would you like whiter teeth.

On a scale of 1-10, how would you rate your smile (10 being a Hollywood smile)? _____