Name _____ Home Phone (___) _____
Last First M

Address _____ City _____ State _____ Zip Code _____

Cell Phone (___) _____ Work Phone (___) _____ E-mail _____

Employer _____ Social Security No. _____ Date of Birth ____/____/____ Sex ☐ M ☐ F

Who were you referred by: _____ Has a family member ever been a patient of our practice? ☐ Yes ☐ No

Emergency Contact _____ Relationship _____ Phone (____) _____

If you are completing this form for another person, what is your relationship to that person? _____

Medical Information

Physician _____
Name Phone Address City/State/Zip

_____

Pharmacy _____
Name Phone Address City/State/Zip

Yes No

☐ ☐ Has there been any change in your general health within the last year?

☐ ☐ Have you had any serious illness, operation, or been hospitalized in the past 5 years? If so, why? _____

Please list all prescription and non-prescription medications, herbal supplements you are taking or have recently taken.

_____ _____

_____ _____

_____ _____

_____ _____

Have you had a serious/difficult problem associated with any previous dental treatment? if so, explain. _____

_____

Have you ever been diagnosed or treated for oral cancer? ☐ Yes ☐ No If yes, explain. _____

Do you take or have ever taken Bisphosphonate medications for osteoporosis or bone density? ☐ Yes ☐ No

Do you take any blood thinners (examples of some Aspirin, Coumadin, Plavix) or have abnormal bleeding? ☐ Yes ☐ No If yes, list medication _____

Do you have TMD (Jaw Joint) Disorder? ☐ Yes ☐ No

Yes No

☐ ☐ Do you drink alcoholic beverages? ☐ Daily ☐ Weekly ☐ Monthly ☐ Socially

☐ ☐ Are you alcohol and/or drug dependent? If so have you received treatment? ☐ Yes ☐ No

☐ ☐ Do you use drugs or other substances for recreational purposes? Please list. _____

☐ ☐ Do you use tobacco (smoking, snuff, chew)? If so, frequency of use. _____

Allergies Are you allergic to or have you had a reaction to:

Yes	No		Yes	No		Yes	No	
☐	☐	Aspirin	☐	☐	Other Antibiotics	☐	☐	Metals
☐	☐	Penicillin/Amoxicillin	☐	☐	Local Anesthetics	☐	☐	Iodine
☐	☐	Erythromycin	☐	☐	Sedatives	☐	☐	Hay Fever/Seasonal
☐	☐	Clindamycin	☐	☐	Codeine/Other Narcotics	☐	☐	Food (Specify) _____
☐	☐	Sulfa drugs	☐	☐	Latex	☐	☐	Eggs/Yolks

To yes responses, specify type of reaction _____

Yes No

☐ ☐ Do you have an artificial heart valve or mitral valve prolapse or heart murmur?

☐ ☐ Have you had an orthopedic total joint (hip, knee, elbow) replacement? If so, when was this operation done? _____

☐ ☐ Has a physician recommended that you take antibiotics prior to your dental treatment? If so, what

Antibiotic and dose? _____

Name of physician _____ Phone _____

Yes No

- ☐ ☐ Autoimmune Disease
- ☐ ☐ AIDS or HIV Infection
- ☐ ☐ Anemia/Blood Disorders
- ☐ ☐ Asthma
- ☐ ☐ Bronchitis
- ☐ ☐ Pneumonia
- ☐ ☐ Rheumatoid Arthritis
- ☐ ☐ Cancer/Chemotherapy/Radiation Therapy
  Explain:_____
- ☐ ☐ Cardiovascular disease **If yes, specify below.**
  - ○ Angina/Chest Pain
  - ○ Arteriosclerosis
  - ○ Artificial heart valves
  - ○ Coronary insufficiency
  - ○ Coronary occlusion
  - ○ Damaged heart valves
  - ○ Heart attack
  - ○ Heart murmur
  - ○ Heart surgery
  - ○ Irregular heart beat
  - ○ Elevated cholesterol
  - ○ High blood pressure
  - ○ Low blood pressure
  - ○ Congenital heart defects
  - ○ Mitral valve prolapse
  - ○ Pacemaker
  - ○ Defibrillator
  - ○ Rheumatic heart disease/Rheumatic fever
- ☐ ☐ Disease, drug or radiation induced immunosuppression
- ☐ ☐ Diabetes
- ☐ ☐ Dry mouth
- ☐ ☐ Emphysema
- ☐ ☐ Eating disorder If yes, specify_____
- ☐ ☐ Epilepsy/Seizures
- ☐ ☐ Fainting Spells
- ☐ ☐ Hepatitis, or Liver Disease
- ☐ ☐ Kidney Ailments/Dialysis
- ☐ ☐ Anxiety Disorder/Depression/Mental Health Disorders
  If yes, specify_____
- ☐ ☐ Migraines or severe headaches
- ☐ ☐ Multiple Sclerosis
- ☐ ☐ Neurological disorders. If yes, specify _____
- ☐ ☐ Osteoporosis/Osteopenia
- ☐ ☐ Osteonecrosis
- ☐ ☐ Sexually transmitted diseases
- ☐ ☐ Sinus trouble
- ☐ ☐ Sleep disorders
- ☐ ☐ Sores/Ulcers in the mouth
- ☐ ☐ Stroke
- ☐ ☐ Lupus
- ☐ ☐ Thyroid problems
- ☐ ☐ Tuberculosis
- ☐ ☐ Stomach Ulcers/Gastritis
- ☐ ☐ Do you have any contagious disease, condition or problem not listed?
  Explain:_____

(Women Only)

Yes No

- ☐ ☐ Are you pregnant?
- ☐ ☐ Nursing?
- ☐ ☐ Taking birth control pills?

Note: Antibiotics may alter the effectiveness of birth control pills. Consult your physician/gynecologist for assistance regarding other methods of birth control.

I certify that I have read and understand the above. 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 _____

For completion by dentist

Comments on patient interview concerning health history _____

_____

_____

_____

Signature of Dentist _____ Date _____

Health History Updates:

Signature of dentist	Comments	Date

John F. Como, D.D.S., P.C.
140 Lockwood Ave., Suite 209
New Rochelle, NY 10801
Phone (914) 632-1111

PATIENT HIPPA AWARENESS

Having read the John F. Como, D.D.S., P.C. Notice of Privacy Practices, I hereby consent to John F. Como, D.D.S., P.C. using and disclosing protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). John F. Como, D.D.S., P.C. reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to The Privacy Officer.

With my permission, the office of John F. Como, D.D.S., P.C. may call my home or other designated locations and leave a message on voicemail at home, work, or cellular in person, or via e-mail or text in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my permission, the office of John F. Como, D.D.S., P.C. may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards, e-mail reminders and patient statements every effort will be made to mark them Personal and/or Confidential.

I have the right to request that John F. Como, D.D.S., P.C. restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does it is bound by this agreement. By signing this, I am allowing John F. Como, D.D.S., P.C. to use and disclose my PHI for TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

FINANCIAL AGREEMENT

The fee for your treatment is determined by the complexity of the treatment required. The fee is payable in full at the time of service unless other arrangements are made in advance. We will be happy to assist you in completing your insurance forms in the event that you have insurance benefits available to reimburse you for fees paid to John F. Como D.D.S., P.C. Upon request we will furnish you with a walk-out statement which is especially prepared to assist you with your insurance claim. The patient is responsible for submitting their claim to their insurance carrier. The office of John F. Como D.D.S., P.C. does not submit insurance claims for patients, but may assist with claims submitted on a case by case basis. If any additional information is requested by your insurance company please contact our office. All fees are the direct obligation of the patient it is the patients responsibility to verify coverage and requirements with your individual carrier.
All remaining balances past due by 60 days, patient/guarantor will be responsible for 1 ½ % service charge per month. There may be a minimum $50 fee for all scheduled appointments broken without at least 48 hours prior notice. For your convenience we accept credit cards, cash and personal checks.

Signature of Patient or Legal Guardian	Date
Print Patient's Name	Print Name of Legal Guardian