Patient Name:	Medical Alert

Welcome!

So that we may provide you with best possible care
Please complete both sides of this medical/dental history form.
All information is completely confidential!

What is the reason for your visit today? _____

Date of Last Dental Visit_____ Last Dental Cleaning_____ Last Full Mouth X-rays_____

What was done at your last dental visit? _____

Previous Dentist's Name _____

Previous Dentist's Address_____

Previous Dentist's Phone #: _____

How often do you have dental examinations? _____

How often do you brush your teeth? _____How often do you floss?_____

What other dental aids do you use? (Interplak, toothpick, etc.)_____

Do you have any dental problems now? Yes No

If yes, please describe: _____

Are any of your teeth sensitive to:

Hot or cold ?	Yes	No
Sweets ?	Yes	No
Biting or Chewing ?	Yes	No
Have you noticed any mouth odors or bad tastes?	Yes	No
Do you frequently get cold sores, blisters or Any other oral lesions?	Yes	No

Do your gums bleed or hurt? Yes No

Have your parents experienced gum disease Or tooth loss?	Yes	No
Have you noticed any loose teeth or change In your bite?	Yes	No
Does food tend to become caught in between your teeth?	Yes	No

If yes, where?

Do You:

Clench or grind your teeth while awake or Asleep ?	Yes	No
Bite your lips or cheeks regularly?	Yes	No
Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails)	Yes	No
Mouth breath while awake or asleep?	Yes	No
Have tired jaws, especially in the morning?	Yes	No
Smoke and or chew tobacco ?	Yes	No

Have you ever had:

Orthodontic treatment?	Yes	No
Oral surgery?	Yes	No
Periodontal treatment?	Yes	No
Your teeth ground or the bite adjusted?	Yes	No
A bite plate or mouth or head?	Yes	No

If so, please describe, including cause_____

Have you experienced:

Clicking or popping of the jaw?	Yes	No
Pain? (joint, ear, side of face)	Yes	No
Difficulty in opening or closing the mouth?	Yes	No
Headaches, neckaches or shoulder aches?	Yes	No
Sore muscles (neck, shoulders)?	Yes	No

Are you satisfied with your teeth's appearance? Yes No

Would you like to keep all of your teeth all of Your life? Yes No

Do you feel nervous about having dental treatment? Yes No

If so, what is your biggest concern? _____

_____

Have you ever had an upsetting dental experience? Yes No

If yes, please describe _____

Is there anything else about having dental treatment that you would like us to know ? Yes No

If yes, please describe _____

_____

_____

_____

(Please complete other side)

Have you been under the care of a medical doctor during the past two years? Yes No

If yes, for what? _____

Physician's Name _____Phone_____

Address_____City_____State_____Zip_____

Have you taken any medication or drugs during the past two years? Yes No

Are you taking any medication, drugs or pills now? Yes No

If yes, please list name and dosage_____

Are you aware of having an allergic (or adverse reaction) to any medication or substance? Yes No

If yes, please list: _____

Have you been a patient in the hospital during the past five years? Yes No

Indicate which of the following you have had, or have at present. (Circle "yes" or "no" to each item.)

Heart (Surgery, Disease or Attack)	Yes	No	Latex Sensitivity	Yes	No
Chest Pain	Yes	No	Allergies or Hives	Yes	No
Heart Murmur	Yes	No	Sinus Trouble	Yes	No
High Blood Pressure	Yes	No	Respiratory Problems	Yes	No
Mitral Valve Prolapse	Yes	No	Cancer	Yes	No
Artificial Heart Valve	Yes	No	Radiation Therapy	Yes	No
Heart Pacemaker	Yes	No	Tumors	Yes	No
Rheumatic Fever	Yes	No	Hepatitis A, B, or C (circle one)	Yes	No
Arthritis/Rheumatism	Yes	No	Venereal Disease	Yes	No
Cortisone Medicine	Yes	No	A.I.D.S.	Yes	No
Swollen Ankles	Yes	No	HIV Positive	Yes	No
Stroke	Yes	No	Cold Sores/Fever Blisters	Yes	No
Head Injuries	Yes	No	Blood Transfusion	Yes	No
Artificial Joints (hip, knee, etc.)	Yes	No	Hemophilia	Yes	No
Kidney Trouble	Yes	No	Anemia	Yes	No
Kidney Stones	Yes	No	Bruise Easily	Yes	No
Ulcers	Yes	No	Blood Thinners	Yes	No
Diabetes	Yes	No	Liver Disease	Yes	No
Thyroid Problems	Yes	No	Yellow Jaundice	Yes	No
Glaucoma	Yes	No	Neurological Disorders	Yes	No
Stomach Problems	Yes	No	Epilepsy or Seizures	Yes	No
Emphysema	Yes	No	Fainting or Dizzy Spells	Yes	No
Chronic Cough	Yes	No	Nervous/Anxious	Yes	No
Tuberculosis	Yes	No	Psychiatric/Psychological Care	Yes	No
Asthma	Yes	No	MRSA (Have had or been exposed)	Yes	No
Hay Fever	Yes	No			

7. Do you use more than two pillows to sleep? Yes No
8. Have you lost or gained more then 10 pounds in the past year? Yes No
9. Do you have or have you had any disease, condition, or problem not listed? Yes No

If yes, please list:

10. **Woman Only** Are you : Pregnant? Yes/No Months ___Num Nursing? Yes /No Taking birth control pills? Yes /No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective Health care provider or agency, which may release such information to you. I will notify the doctor of any change in my health or Medication.

Patient/Guardian Signature Date

Dr. Eric R. Shantzer

My Medication List

Name: _____Date_____
Physician/Phone Number: _____Fax: _____
Pharmacy/ Phone Number: _____Fax:_____
Please list below all prescriptions, over-the-counter medicines, vitamins, herbs, dietary supplements, oxygen, inhalers and homeopathic remedies.

Medication Name	**Dose** (mg, drops, etc.)	**When Taken** (daily, at bedtime, etc.)	**Reasons for Taking** (blood pressure, diabetes, etc.)

Allergies and Reactions (please describe):

Universal Medication Form
Dr. Eric R. Shantzer
Medication list 07/07
(Office) 1-215-396-9200 (FAX) 1-215-396-9230

Who referred you to this office? _____ Social Security # _____

Patient's Name_____ Birthdate _____

Address _____ City _____ ST____ ZIP _____

Home Phone _____ Work Phone _____ Ext _____

Cell Phone_____ Pager_____ E-Mail_____

Employer _____ City _____ Occupation _____

Name of Spouse / Parent / Guardian _____ Birthdate_____
(circle one) Social Security # _____

Address if different_____ City_____ ST_____ZIP_____

Home Phone _____ Work Phone _____ Ext_____

Employer _____City _____ Occupation _____

In case of emergency, whom shall we notify other than spouse?

Name_____ Relationship_____ Phone_____

INSURANCE INFORMATION

EMPLOYEE NAME _____

INS CO NAME_____

INS CO ADDRESS _____

INS CO CITY, ST, ZIP_____

INSURANCE PHONE _____

GROUP / POLICY # _____

EMPLOYEE SS # _____

BIRTHDATE _____

INSURANCE INFORMATION

EMPLOYEE NAME _____

INS CO NAME_____

INS CO ADDRESS _____

INS CO CITY, ST ZIP _____

INSURANCE PHONE _____

GROUP / POLICY # _____

EMPLOYEE SS # _____

BIRTHDATE _____

ASSIGNMENT and RELEASE: I hereby authorize my insurance benefits to be paid directly to the dentist. I am financially responsible for any balances due. I also authorize the dentist to release any information required for this claim. I authorize that my records may be used by the dentist if he so determines. If I am receiving dental hygiene services only, I understand that if any dental or medical problems are discovered during the course of my dental hygiene treatment, I will be referred to the appropriate dental or medical expert for any needed evaluation.

In consideration of the service rendered to me by this dental office, I am obligated to pay said office in accordance with its credit terms and policy.

I consent to the taking of photographs and x-rays before, during, and after treatment, and to the use of same by the doctor in scientific papers or demonstrations.

I certify that I have read or had read to me, the contents of this form.

I have read the above: Signature _____ Date _____
Parent or Guardian if a minor

Consent for Purposes of Treatment, Payment, and Healthcare Operations

Eric R. Shantzer, D.D.S.

Although this form is no longer required for HIPAA compliance, you are being asked to sign this form because it is either required for state or other compliance. If you have any questions about this form please contact our HIPAA Privacy and Security Expert who is Lois McCann.

CONSENT

I consent to the use or disclosure of my protected health information by Eric R. Shantzer, D.D.S. for the purpose of diagnosing me or providing treatment to me, for obtaining payment for my health care bills, or to conduct the health care operations of this organization. I understand that diagnosis or treatment of me by my dentist may be dependent upon my consent as evidenced by my signature on this document.

RESTRICTION ON THE DISCLOSURE OF MY PROTECTED HEALTH INFORMATION

I understand that I have the right to request that this organization restrict the way my protected health information is used or disclosed in order to treat me, to obtain payment, or for the other healthcare operations of the organization. The organization is not required to agree to the restrictions that I may request, but if the organization does agree to a restriction that I request, the restriction is binding on the organization and on the staff.

REVOKE CONSENT

I have the right to revoke this consent, in writing, at any time, except to the extent that my dentist or this organization already has taken action based upon this consent.

DEFINITION OF PROTECTED HEALTH INFORMATION

My "protected health information" means health information, including my demographic information such as but not limited to my age, my occupation, and the address at which I live, collected from me and created or received by my dentist, another health care provider, a health plan, my employer, a health care clearinghouse, or any other entity that uses or creates health information about me and that has a business relationship with this organization. This protected health information relates to my past, present or future physical or mental health or condition and either identifies me, or there is a reasonable basis to believe that the information might identify me. It does not include certain education records covered by the Family Educational Rights and Privacy Act, and records held by a covered entity in its role as an employer; those exclusions may not apply to you as a patient of this practice.

RIGHT TO REVIEW THE NOTICE OF PRIVACY PRACTICES

I understand that I have the right to review this organization's Notice of Privacy Practices before I sign this consent document. That document has been provided to me. The Notice of Privacy Practices describes the way my protected health information will be used or disclosed during my treatment, during the payment of my bills, or during the performance of the health care operations of this organization. The Notice of Privacy Practices for this organization is also provided MAIN LOBBY and on the organization's website at http://hipaacaat.com. This Notice of Privacy Practices also describes my rights and this organization’s duties with respect to my protected health information.

Eric R. Shantzer, D.D.S. reserves the right to change the privacy practices that are described in our Notice of Privacy Practices to better protect your personal information. I understand that I can obtain a revised Notice of Privacy Practices by accessing the organization’s website, calling or faxing the office and requesting that a revised copy be sent to me in the mail, or by asking for a revised notice at the time of my next appointment.

_____
Signature of Patient or Personal Representative

_____
Name of Patient or Personal Representative

_____
Date

_____
Description of Personal Representative’s Authority