Medical History Form

Gordon and Maltz, PC

Patient Information (Confidential)

Patient Name:____

Date of Birth	Sex: Male or Female	Today's date
Home phone	Cell Phone	Work Phone
Email	Fax	SSN

Patient's **mailing address**____

Unit/Apt Number____

City ____________________ State _________ Zip code __________________

Patient's **Employer** ____ Employer phone__________________

Business Address ____

Unit/Apt Number ____

City ____________________ State _________ Zip code __________________

Circle which

Spouse's / Parent name ____

Phone number ____

Employer ____ Employer phone number ______________________

Emergency contact ___________________________________ Phone number____________________________

Authorization and Release

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. 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.

X____

Signature of patient (or parent if minor

Please continue to back side

Medical Information

Medical Doctor ______________________ Phone ____________________ Date of last exam________

1. Are you under medical treatment now? -- Yes / No
2. Have you ever been hospitalized for any surgical operation or serious Illness within the last 5 years? -- Yes / No

   If yes, please explain ____

   ____

3. Are you taking any medications including non-prescription medicine? ------------------ Yes / No

   If yes, what medications are you taking?____

   ____

4. Do you smoke cigarettes? -- Yes / No

   If yes, how many per day?____

5. Do you use controlled substances? -- Yes / No

6. Are you **allergic** to or have you had any reactions to the following?(check the box if answering "yes")

- ❑ Local Anesthetics (e.g. novocaine)
- ❑ Penicillin or any other antibiotics
- ❑ Sulfa Drugs
- ❑ Barbiturates
- ❑ Sedatives
- ❑ Iodine
- ❑ Aspirin
- ❑ Any Metals (Nickel, Mercury, etc.)
- ❑ Latex Rubber
- ❑ Other: ______________________

  ____

7. Do you have or have you had any of the following? (check the box if answering "yes")

- ❑ High Blood Pressure
- ❑ Heart Disease
- ❑ Heart Attack
- ❑ Rheumatic Fever
- ❑ Swollen Ankles
- ❑ Fainting / Seizures
- ❑ Cardiac Pacemaker
- ❑ Heart Murmur
- ❑ Angina
- ❑ Mitral Valve Prolapse
- ❑ Chest Pains
- ❑ Recent Weight Loss
- ❑ Asthma
- ❑ Respiratory Problems
- ❑ Epilepsy / Convulsions
- ❑ Leukemia
- ❑ Diabetes
- ❑ Kidney Disease
- ❑ Sexually Transmitted Disease
- ❑ AIDS / HIV Infection
- ❑ Thyroid Problem
- ❑ Frequent Fatigue
- ❑ Anemia
- ❑ Emphysema
- ❑ Cancer
- ❑ Arthritis
- ❑ Joint Replacement or Implant
- ❑ Liver Disease
- ❑ Hepatitis / Jaundice
- ❑ Stomach Troubles / Ulcers
- ❑ Easily Winded
- ❑ Stroke
- ❑ Tuberculosis
- ❑ Radiation Therapy
- ❑ Glaucoma
- ❑ Other______________

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CENTERS FOR IMPLANT DENTISTRY AND PERIODONTAL SPECIALTY CARE

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Tel: 845.343.0519

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Poughkeepsie, NY 12603
Tel: 845.226.5156

PATIENT HIPPA AWARENESS

With my permission, Drs. Gordon & Maltz may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Drs. Gordon & Maltz Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Drs. Gordon & Maltz reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Privacy Officer.

With my permission, the office of Drs. Gordon & Maltz may call my home or other designated locations and leave a message on voice mail or in person 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 Drs. Gordon & Maltz may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal or Confidential.

With my permission, the office of Drs. Gordon & Maltz may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Drs. Gordon & Maltz 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 Drs. Gordon & Maltz 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.

____
Signature of Patient or Legal Guardian

______________________________ ______________
Patients' Name Date

____
Print Name of Patient or Legal Guardian