HEALTH HISTORY UPDATE & INFORMATION

EMAIL: **DATE:** / /

Name: **H:** **C:**

ADDRESS:

SEX:

OCCUPATION: **DOB:** **SSN**:

EMERGENCY CONTACT INFORMATION:
Name & Phone:

APPOINTMENT CONFIRMATION: Circle one: SMS (TEXT) / EMAIL / CELL / HOME

When our office abides by your request and you do not honor your agreement, ***please respect our policy and need to charge a fee****. Our relationship is mutually important to provide sufficient time and effective business practices.*

X ______________________________

(Patient Signature)

How were you referred to our practice? Circle One: FRIEND/FAMILY FACEBOOK INTERNET

If you were referred by a patient, please provide his/her name: ______________________________

Dental Information *For the following questions, please mark your responses in each respective box (X).*

Question	Yes	No
Do your gums bleed when you brush or floss?	☐	☐
Are your teeth sensitive to cold, hot, sweets, or pressure?	☐	☐
Does food or floss catch between your teeth?	☐	☐
Is your mouth dry?	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐
Have you ever had orthodontic (braces) treatments?	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐
Is your home water supply fluoridated?	☐	☐
Do you drink bottled or filtered water?	☐	☐
If yes, how often? Circle one: DAILY/WEEKLY/OCCASIONALLY		
Are you currently experiencing dental pain or discomfort?	☐	☐

Question	Yes	No
Do you have earaches or neck pains?	☐	☐
Do you have any clicking, popping, or discomfort in the jaw?	☐	☐
Do you brux or grind your teeth?	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐
Do you wear dentures or partials?	☐	☐
Do you participate in active recreational activities?	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐
Do you snore?	☐	☐

What is the reason for your dental visit today?

____

____

Have you had a change in insurance since your last visit? ☐ Yes ☐ No

If yes, please provide new information to our front desk.

Medical Information *For the following questions, please mark your responses in each respective box (X).*

Question	Yes	No
Are you now under the care of a physician?	☐	☐

Physician Name: Phone: ( )

Address/City/State/Zip:

Question	Yes	No
Are you in good health?	☐	☐
Has there been any change in your general health within the past year?	☐	☐

If yes, what condition is being treated?

____

Date of last physical exam: ______________________________

Question	Yes	No
Have you had a serious illness, operation, or been hospitalized in the past 5 years?	☐	☐

If yes, what was the illness or problem? ______________________________

Medication(s): List all ***current*** medications (include vitamins, supplements, over the counter medicines, and prescriptions) and reasons below

Medication Name	*Reason*	*Medication Name*	*Reason*

HEALTH HISTORY UPDATE & INFORMATION CONTINUED

Question	Yes	No
Do you wear contact lenses?	☐	☐
Joint Replacement. Have you had an orthopedic total Joint (hip, knee, elbow, finger) replacement?	☐	☐
Are you taking or scheduled to be taking either of the Medications, alendronate (Fosamax®), or risedronate (Actone®l) for osteoporosis or Paget's disease?	☐	☐
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia, or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?	☐	☐

Date Treatment Began: ____________

Question	Yes	No
Do you used controlled substances (drugs)?	☐	☐
Do you use tobacco (smoking, snuff, chew, bidis)?	☐	☐
If so, how interested are you in stopping?	☐	☐

(Circle one) VERY / SOMEWHAT / NOT INTERESTED

Question	Yes	No
Do you drink alcoholic beverages?	☐	☐

If yes, how much do you typically drink in a week? ____________

WOMEN ONLY Are you:

Question	Yes	No
Pregnant?	☐	☐
Number of weeks? ____________		
Taking birth control pills or hormonal replacement?	☐	☐
Nursing?	☐	☐

Allergies- Are you allergic to or have you had a reaction to:
To all **yes** responses, specify type of reaction.

Allergy	Yes	No
Local anesthetics ____________	☐	☐
Aspirin ____________	☐	☐
Penicillin or other antibiotics ____________	☐	☐
Barbiturates, sedatives, or sleeping pills ____________	☐	☐
Sulfa drugs ____________	☐	☐
Codeine or other narcotics ____________	☐	☐
Metals	☐	☐
Latex (rubber)	☐	☐
Iodine	☐	☐
Hay fever/seasonal	☐	☐
Animals	☐	☐
Food	☐	☐
Nuts	☐	☐
Other	☐	☐

Please mark (x) your response to indicate if you have or have not had any of the following diseases or problems.

Condition	Yes	No
Artificial (prosthetic) heart valve	☐	☐
Previous infective endocarditis	☐	☐
Damaged valves in transplanted heart	☐	☐
Congenital heart disease (CHD)	☐	☐
Unrepaired, Cyanotic CHD	☐	☐
Repaired (completely) in last 6months	☐	☐
Repaired CHD with residual defects	☐	☐

Except for the conditions listed above, antibiotic prophylaxis is no Longer recommended for any other form of CHD.

Condition	Yes	No
Cardiovascular disease	☐	☐
Angina	☐	☐
Arteriosclerosis	☐	☐
Congestive heart failure	☐	☐
Damaged heart valves	☐	☐
Heart attack	☐	☐
Heart murmur	☐	☐
Low blood pressure	☐	☐
High blood pressure	☐	☐
Other congenital heart Defects	☐	☐
Thyroid Problems	☐	☐
Stroke	☐	☐
Mitral Valve Prolapse	☐	☐
Pacemaker	☐	☐
Rheumatic Fever	☐	☐
Rheumatic Heart Disease	☐	☐
Abnormal bleeding	☐	☐
Blood transfusion — If yes, date: ________		
Hemophilia	☐	☐
AIDS or HIV	☐	☐
Arthritis	☐	☐
Glaucoma	☐	☐
Kidney Problems	☐	☐
Autoimmune disease	☐	☐
Rheumatoid Arthritis	☐	☐
Systemic Lupus Erythematosus	☐	☐
Asthma	☐	☐
Bronchitis	☐	☐
Emphysema	☐	☐
Sinus Trouble	☐	☐
Tuberculosis	☐	☐
Cancer/Chemotherapy, Radiation Treatment	☐	☐
Chest pain upon Exertion	☐	☐
Chronic pain	☐	☐
Diabetes Type I or II	☐	☐
Eating Disorder	☐	☐
Malnutrition	☐	☐
Gastrointestinal Disease	☐	☐
G.E Reflux/Heartburn	☐	☐
Ulcers:	☐	☐
Hepatitis, jaundice, or liver disease	☐	☐
Epilepsy	☐	☐
Fainting spells or seizure	☐	☐
Neurological disorders — If yes, specify: ________	☐	☐
Sleep Disorder	☐	☐
Mental Health Disorders — Specify: ________	☐	☐
Recurrent Infections — Type of infection: ________	☐	☐
Night sweats	☐	☐
Osteoporosis	☐	☐
Persistent swollen glands in neck	☐	☐
Severe headaches/migraines	☐	☐
Severe or rapid weight loss	☐	☐
Sexually transmitted disease	☐	☐
Excessive urination	☐	☐

Question	Please list Medication Below	Yes	No
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	____________	☐	☐

Name of a physician or dentist making recommendation: ____________ Phone: (   )

Question	Yes	No
Do you have any disease, condition, or problem not listed above that we should know about?	☐	☐

Note: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. 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:** ____________

Family Dentistry of West Bloomfield

RONALD BERRIS DDS PC & JULIE K. GOLDSTEIN DDS

6400 Farmington Rd., West Bloomfield, MI 48322 248-661-4000 Fax 248-661-4003

PATIENT CONSENT/ACKNOWLEDGEMENT FORM

Effective April 14, 2003, the new federal law known as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that our office comply with certain rules regarding the maintenance of your information that we have collected and will collect in the future. By signing below, you consent to the use and disclosure of your protected health information by RONALD BERRIS D.D.S., P.C., our staff, and our business associates for treatment, payment and health care operations.

For a more detailed description of uses and disclosures for these purposes, please request and review our Notice of Information Practices ("Notice"). You have the right to review our Notice prior to signing this consent. The terms of this Notice may change. If they do, you may request a revised Notice by contacting this office (248) 661-4000. We will also post any revised notice in the office.

From time to time it may be necessary for us to make disclosures of your information in connection with your treatment. For example, we may make a referral to or consult with another dentist or other health care professional or make disclosures of your information in connection with providing or coordinating your treatment. You have the right to request that we restrict our uses or disclosures of your protected health information that we are otherwise permitted to make fore treatment, payment and health care operations. If we agree to further restrictions, they are binding on us. However, we are not required to agree to these restrictions. Finally, you may refuse to consent to the use or disclosure of your protected health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Protected Health Information (PHI).

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**** You May Refuse to Sign This Acknowledgement ****

I, ____________________________________, am aware of and understand this office's Notice of Privacy Practices. I understand that I may request a copy of this Notice.

Please Print Name ____ **Signature**X______________________________________ **Date** _______________

The above consent will apply to my children of record until they attain the age of 18.

FOR OFFICE USE ONLY

____

We attempted to obtain written acknowledgement 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

____

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COMPLIANCE FORM

Our office calls to confirm appointments. This courtesy is labor intensive, time-consuming, and often requires several calls in an effort to reach the patient in person. The majority of patients remember schedule appointments and appreciate time reserved for their dental care. We appreciate your commitment and respect in honoring scheduling obligations. When a patient breaks or re-schedules their appointment without sufficient notice, the doctor or hygienist treatment time is unproductive. **Office policy is to charge a fee for broken appointments. In some instances, a fee has been charged for re-scheduled or cancelled appointments without 24 hours' notice.** This policy, because of our close relationship, has been difficult to implement and enforce. To reduce overhead costs and labor constraints, a change in appointment confirming is necessary. Improved efficiency requires shifting more responsibility to the patient.

For our new confirmation policy, we request that you indicate the cell and/or email procedure necessary to confirm your appointments.

Cell phone confirmation: **YES** **NO**
Cell phone number for Texting: ___________________________________

Email confirmation: **YES** **NO**
Email address: ____

When our office abides by your request and you do not honor your agreement, **please respect our policy and need to charge a fee.** Our relationship is mutually important to provide sufficient time and effective business practices.

Please sign and date below. This form will become a part of your permanent record.

X ____

Patient Signature Date