KONECNY DENTISTRY
General and Cosmetic Dentistry

Health History Form

Email:	Today's Date:

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: Last First Middle		Home Phone: ( )	Business/ Cell: ( )	
Adress: Mailing address		City:	State:	Zip:
Occupation:	Height:	Weight:	Date Of Birth:	Sex: M F
SS# or Patient ID: Emergency Contact:		Relationship:	Home phone: ( )	CellPhone: ( )

Do you have any of the following diseases or problems? **(Check DK if you don't know the answer)**

	Yes	No	DK
Active Tuberculosis……	☐	☐	☐
Persistant cough greater than 3 weeks duration……..	☐	☐	☐
Cough that produces blood……	☐	☐	☐
Been exposed to anyone with tuberculosis……	☐	☐	☐

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Dental Information

For the following questions, please mark (X)your responses.

	Yes	No	DK
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 hever had any problems associated with previous dental treatments?.....	☐	☐	☐
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?.....	☐	☐	☐
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 sore or ulcers in your mouth?.....	☐	☐	☐
Do you have dentures or partials? ……	☐	☐	☐
Do you participate in active recreational activities?.....	☐	☐	☐
Have you ever had a serious injury to your head or mouth?.....	☐	☐	☐

Date of your last dental exam: Date of last dental xrays:

What was done at this time? What is the reason for today's visit?

How do you feel about your smile?

Medical Information

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

	Yes	No	Dk
Are you under the care of a physician?.....	☐	☐	☐
Physician Name: Phone: ( )			
Address/ City/ State/ Zip:			
Are you in good health?.....	☐	☐	☐
Has there been any changes in your general health within the past year?.....	☐	☐	☐
If yes, what condition is being treated? _____ _____			
Date of last physical exam:_____			
Have you had a serious illness, operation or been hospitalized in the past 5 years?.....	☐	☐	☐
If yes, what was the illness or problem? _____ _____			
Are you taking or have you recently taken any prescription or over the counter medicine(s)?.....	☐	☐	☐
If so, please list all, including vitamins, natural or herbal preparations, and/or diet supplements: _____ _____ _____ _____ _____			
Do you wear contact lenses?.....	☐	☐	☐
Joint Replacement. Have you ever had a orthopedic total joint (hip, knee elbow, finger) replacement?.....	☐	☐	☐
Date: If yes, have you had any complications?			
Are you taking or scheduled to be taking either of the medications alendronate (Fosamax) or reisedronate (Actonel) for osetoprosis or Paget's disease? ……..	☐	☐	☐
Since 2001, were you treated or are you presently scheduled to beign treatment with the intravenous bisphonates (Aredia or Zometa) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?.....	☐	☐	☐
Date treatment began:_____			
Do you use 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			
Do you drink alcoholic beverages?.....	☐	☐	☐
If yes, how much alcohol did you drink in the last 24 hrs? _____			
If Yes, how much do you typically drink in a wee week?			
WOMEN ONLY Are you:			
Pregnant?	☐	☐	☐
Number of weeks:_____			
Nursing? ……	☐	☐	☐
Taking Birth control pills or hormonal replacement?.....	☐	☐	☐

	Yes	No	Dk
Allergies - Are you allergic to or have you had a reaction to:			
To all yes responses, specify type of reation.			
Local anesthetics …….	☐	☐	☐
Aspirin ……...	☐	☐	☐
Penicillin or other antibiotics …….	☐	☐	☐
Explain:			
Barbiturates, sedatives, or sleeping pills …….	☐	☐	☐
Sulfa drugs …….	☐	☐	☐
Codeine or other narcotics …….	☐	☐	☐
Metals …….	☐	☐	☐
Latex (rubber) ……..	☐	☐	☐
Iodine …….	☐	☐	☐
Hay fever / seasonal …….	☐	☐	☐
Animals……..	☐	☐	☐
Food ……..	☐	☐	☐
Other …….	☐	☐	☐

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

	Yes	No	Dk
Artificial (prosthetic) heart valve ……	☐	☐	☐
Previous infective endocarditis ……	☐	☐	☐
Damaged valves in transplanted heart …….	☐	☐	☐
Congenital heart disease (CHD)			
Unrepaired, cyanotic CHD …….	☐	☐	☐
Repaired (completely) in last 6 months ……..	☐	☐	☐
Repaired CHD with residual defects …….	☐	☐	☐
Cardiovascular Disease	☐	☐	☐
Angina ……..	☐	☐	☐
Arteriosclerosis ……	☐	☐	☐
Congestive heart failure ……..	☐	☐	☐
Damage heart valves ……..	☐	☐	☐
Heart attack …….	☐	☐	☐
Heart murmur ……..	☐	☐	☐
Low blood pressure …….	☐	☐	☐
High blood pressure ……	☐	☐	☐
Other congential heart defects ……	☐	☐	☐
Mitral valve prolaspe…….	☐	☐	☐
Pacemaker …….	☐	☐	☐
Rheumatic fever ……..	☐	☐	☐
Rheumatic heart disease ……..……	☐	☐	☐
Abnormal bleeding ……..	☐	☐	☐
Blood transfusion …….	☐	☐	☐
If yes, date: _____			
Hemophilia ……	☐	☐	☐
AIDS or HIV infection ……	☐	☐	☐
Arthritis ……	☐	☐	☐
Autoimmune disease …….	☐	☐	☐
Rheumatiod arthritis ……	☐	☐	☐

	Yes	No	Dk
Systemic lupus erythematosus ……	☐	☐	☐
Asthma ……	☐	☐	☐
Bronchitis ……..……	☐	☐	☐
Emphysema ……	☐	☐	☐
Sinus trouble ……	☐	☐	☐
Cancer/Chemotherapy/radiation treatment …….	☐	☐	☐
Chest pain upon exertion……	☐	☐	☐
Chronic pain ……..	☐	☐	☐
Diabete Type I or II	☐	☐	☐
Eating disorder …….	☐	☐	☐
Malnutrition ……..……	☐	☐	☐
Gastronintestinal disease ……..	☐	☐	☐
G.E. reflux/persistent heartburn ……	☐	☐	☐
Ulcers ……	☐	☐	☐
Thyroid problems …….	☐	☐	☐
Stroke ……	☐	☐	☐
Glaucoma ……..	☐	☐	☐
Hepatitis, jaundice or liver disease ……..	☐	☐	☐
Epilepsy ……	☐	☐	☐
Fainting spells or seizures ……	☐	☐	☐
Neurological disorders ……	☐	☐	☐
If yes, specify: _____			
Mental health disorders …….	☐	☐	☐
If yes, specify: _____			
Recurrent Infections ……	☐	☐	☐
Type of infection: _____			
Kidney problems ……	☐	☐	☐
Night sweats ……	☐	☐	☐
Osteoporosis ……	☐	☐	☐
Persistent swollen glands in neck ……	☐	☐	☐
Severe headaches/ migraines ……..	☐	☐	☐
Severe or rapid weight loss …….	☐	☐	☐
Sexually transmitted disease ……	☐	☐	☐
Excessive urination ……	☐	☐	☐
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ……..	☐	☐	☐

Name of physician or dentist making recommendation: Phone:

Do you have any disease, condition, or problem not listed above that you think I should know about? …… ☐ ☐ ☐

Explain:

NOTE: **Both Doctor and patient are encouraged to discuss any/all relevant patient health issues and or concerns prior to any 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 staff will rely on this information for treating me. I acknowlwdge that my questions,if any,about inquiries set forth above have been answered to my satisfaction. I will not hold my Dentist, or any 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:

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CONSENT FOR TREATMENT

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 providers or agency, who may release such information to you. I will notify this office of any change in my health or medication. I give permissions for Dr. Konecny and his clinical team to take any necessary diagnostic films, photos, or study models to properly enable complete diagnosis and treatment.

CANCELLATION POLICY

We reserve the right to charge for appointments canceled or broken without 24hr advance notice. We consider all of our appointments as confirmed at the time they are made. If you would like a courtesy reminder, please let us know. We do ask however, that you review your commitments carefully before reserving time with us to minimize appointment changes. We reserve the right to charge $25.00 for the duplication of any x-rays.

PAYMENT POLICY

We promise all of our patients that we will reach an understanding about both cost and how that cost will be handled, before you commit to an appointment. We know this is an important consideration for you. No treatment will be performed until it has been fully explained to you and financial arrangements have been made.

FINANCIAL AGREEMENT

The patient, guarantor, or legally authorized representative individually obligates him/her self and guarantees prompt payment of all charges. If payment is not received within 30 days of the date of final billing, finance charges may accrue and balance may be turned over for collection activity. You also agree to pay any collection agency fee necessary in collecting a balance. You also consent to pay a $25.00 return check fee for each check that is returned by my bank for insufficient funds or closed accounts.

INSURANCE POLICY

We will file any standard insurance you may have at no additional charge, given you furnish us with the proper information. You must contact your insurance company to review what type of coverage you have and if there are any restrictions. Your dental insurance is a private contract between you and your insurance company. All efforts on our part will be given to file your insurance however, it will be your responsibility to contact your insurance company to correct any problems if we do not receive payment. Every effort is done to estimate what your insurance may pay based on the information provided to us from YOUR insurance company. This is not a guarantee that your insurance company will pay this amount and you will be responsible for any or all balances the **insurance does not pay.**

_____ _____

Patient / Guardian Signature **Date**

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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:

- o Individual refused to sign
- o Communication barriers prohibited obtaining acknowledgement
- o An emergency situation prevented us from obtaining acknowledgement at this time
- o Other (please specify)

_____
_____
_____
_____

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KEEP FOR YOUR RECORDS

Notice of Privacy Policy
HIPPA Compliance

We value you as a patient and provide this notice to explain that we will do the following to respect and safeguard your privacy:

1. We will never share your personal or health information with other for any reason without your consent. We will ask you to designate those persons with whom we can share your information with, and share only information necessary with designated persons.

2. We collect personal / health information from you when you are a patient under our care, including but not limited to: name, date of birth, address, contact information, social security number, dental insurance information, and potentially past dental records should it be required. We only collect the above information about you to provide you with the proper treatment and/ or diagnosis.

3. We maintain safeguards on our patients' personal information and all dental records. The information is only used as needed to provide the best care for our patients, such as for verifying insurance benefits, processing insurance claims, and dental charting. Only the staff members responsible of such things will have access to your information.

4. We may disclose information when required by law in order to respond to a subpoena, prevent fraud, or comply with an injury by a government agency.

5. When you give us a written request to do so, we will share your patient records with a new doctor you have selected.

6. When you give us written permission to do so, we will share your information with your insurance carrier in order to process claims, verify coverage, etc. In some cases it is necessary refer patients to other specialist, in this event we would need to share your information with the new provider in the best interest of your health and the care that is needed. This will NOT be done with out your consent and complete understanding of the necessity to see another Doctor.

7. You have the right to inspect and copy your dental records. You may request to amend the information but you DO NOT have the right to change dental record. The doctor has the final say about amending information if he disagrees with the request. You can revoke your authorization by written request at any time but not for work already processed.

8. We will update you each year on our privacy practices / policies and any changes that have occurred.