Patient Health Record

In order to help me render the proper dental services to you, would you please be kind enough to answer the following questions. Please note the space for remarks for any answers that require clarification or any other information you think I should have. Thank you for your cooperation.

DATE _____ E-MAIL _____

NAME _____ (Last) _____ (First) _____ (Middle)

ADDRESS _____ CITY _____ ZIP CODE _____

HOME PHONE _____ WORK PHONE _____ CELL _____

DATE OF BIRTH _____ SEX _____ HEIGHT _____ WEIGHT _____ OCCUPATION _____

MARITAL STATUS (check) SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED ☐

SPOUSE'S NAME _____

REFERRED BY _____ SOCIAL SECURITY NO. _____

EMPLOYER NAME/ADDRESS _____

INSURANCE COVERAGE _____ POLICY NO. _____

MEDICAL HEALTH

General health (please check): EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR ☐

Name and address of physician _____

Last complete physical? _____

Are you taking any medication now? Yes ☐ No ☐ For what purpose? _____

Are you taking bisphosphonates (such as Fosamax) Yes ☐ No ☐

Have you ever been treated for:

Heart disease..... Yes ☐ No ☐
Rheumatic fever..... Yes ☐ No ☐
Abnormal blood pressure..... Yes ☐ No ☐
Ulcers..... Yes ☐ No ☐
Tuberculosis or lung disease.. Yes ☐ No ☐
Diabetes..... Yes ☐ No ☐
Epilepsy..... Yes ☐ No ☐
Anemia..... Yes ☐ No ☐
Congenital heart lesions..... Yes ☐ No ☐
Artificial Joints..... Yes ☐ No ☐

Heart murmur..... Yes ☐ No ☐
Jaundice..... Yes ☐ No ☐
Asthma or hay fever..... Yes ☐ No ☐
Sinus trouble..... Yes ☐ No ☐
Cough..... Yes ☐ No ☐
Hepatitis..... Yes ☐ No ☐
Arthritis..... Yes ☐ No ☐
Stroke..... Yes ☐ No ☐
Glaucoma..... Yes ☐ No ☐
Tobacco User..... Yes ☐ No ☐

Have you ever been treated (other than diagnostic) with x-ray?..... Yes ☐ No ☐
Are you allergic to: Penicillin ☐ Codeine ☐ Local injected anesthetics ☐ Other medications ☐ _____
Are you subject to prolonged bleeding?..... Yes ☐ No ☐
Are you subject to fainting spells?..... Yes ☐ No ☐
Do you have excessive urination and/or thirst?..... Yes ☐ No ☐

(women)

Are you pregnant?..... Yes ☐ No ☐ How long? _____
Have you ever been tested for A.I.D.S. virus in the past 12 months..... Yes ☐ No ☐
Do you have A.I.D.S. or A.R.C. or tested H.I.V. positive?..... Yes ☐ No ☐

(over)

DENTAL HEALTH

Reason for visit:_____

When was your last dental visit?_____

Have you ever had any serious problem associated with previous dental treatment?.....Yes ☐No ☐

If so, explain:_____

_____

How often do you brush your teeth?_____

What texture brush do you use? SOFT ☐ MEDIUM ☐ HARD ☐ NYLON ☐ NATURAL ☐

How often do you floss?_____

Do your gums bleed while brushing?.....Yes ☐No ☐

Do your gums bleed when flossing?.....Yes ☐No ☐

Do you avoid brushing any part of your mouth because of pain?.....Yes ☐No ☐

If yes, what part? _____

Do you feel twinges of pain when your teeth come in contact with:

a) hot foods or liquids, i.e., soup, coffee, tea, etc.?.....Yes ☐No ☐

b) cold foods or liquids, i.e., ice cream, cold fruit, etc.?.....Yes ☐No ☐

c) sweets, i.e., candy, fruit, sweet desserts, etc.?.....Yes ☐No ☐

d) sours, i.e., lemons, limes, grapefruit, etc.?.....Yes ☐No ☐

Do you feel pain to any of your teeth when brushing or flossing them?.....Yes ☐No ☐

Do you chew on only one side of your mouth?.....Yes ☐No ☐

If yes, explain: _____

Do your gums feel tender or swollen?.....Yes ☐No ☐

Do you clench or grind your jaws while sleeping or during the day?.....Yes ☐No ☐

Do your jaws ever feel tired?.....Yes ☐No ☐

Do you wear dentures?.....Yes ☐No ☐

Do you usually have many cavities?.....Yes ☐No ☐

Do you lose fillings or break fillings?.....Yes ☐No ☐

Do you gag easily?.....Yes ☐No ☐

Are you familiar with the terms "preventive dentistry"?.....Yes ☐No ☐

Have you had previous periodontal treatment?.....Yes ☐No ☐

Do you presently have dental implants?.....Yes ☐No ☐

Please add anything you feel is important: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

I understand that I am responsible for my account.

_____

(Patient signature)

AUTHORIZATION FORM

Authorization for Use or Disclosure of Information for Purposes by the office of Richard S. Leiderman, D.M.D.

I, _____, hereby authorize Dr. Richard S. Leiderman to use the following protected health information, and/or disclose the following protected health information to _____

_____

_____

_____

This protected health information is being used or disclosed for the following purposes:

_____

This authorization shall be in force and effect until _____

_____

at which time this authorization to use or disclose this protected health information expires.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the contact, Dr. Richard S. Leiderman, 7390 N.W. 5th Street, Suite 9, Plantation, Florida 33317.

I understand that a revocation is not effective to the extent that Richard S. Leiderman has relied on the use or disclosure of the protected health information.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. Richard S. Leiderman, D.M.D., will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits on "whether I provide authorization for the requested use or disclosure."

I understand that I have the right to:

- *Inspect or copy the protected health information to be used or disclosed as permitted under federal law or state law.*
- *Refuse to sign this authorization.*

  The use or disclosure requested under this authorization will result in direct or indirect remuneration to the office of Dr. Richard S. Leiderman, from a third party.

Signature of Patient or Personal Representative: _____

Date _____

Name of Patient or Personal Representative: _____

Description of Personal Representative's Authority _____

Richard S. Leiderman, D.M.D.

7390 N.W. 5th Street, Suite 9
Plantation, FL 33317

Acknowledgement of Notice of Privacy Practices

You may refuse to sign this form.

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 acknowledgment could not be obtained because: (please check the reason)

☐ Individual refused to sign

☐ Communications barriers prohibited the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgment

☐ Other (specify):

_____

_____

_____

_____

_____

_____

_____