

**History and Insurance Information**

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Marital Status** \_\_\_\_\_  
**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_  
**Home phone:** \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_ **Work phone:** \_\_\_\_\_  
Occupation \_\_\_\_\_ Employer Name \_\_\_\_\_  
**SSN/ID #** \_\_\_\_\_ **E-mail** \_\_\_\_\_  
Spouse/Guarantor \_\_\_\_\_  
**Name of Dentist:** \_\_\_\_\_ How Long? \_\_\_\_\_ City \_\_\_\_\_  
Name of Physician \_\_\_\_\_ How Long? \_\_\_\_\_ City \_\_\_\_\_  
Whom may we thank for referring you to this office? \_\_\_\_\_  
Reason for visit \_\_\_\_\_

**Periodontal disease is produced by a combination of complex elements. It is necessary to determine every possible contributing factor. The success of therapy is most dependent upon this. Though some of the following questions may seem unrelated to your gum condition, they are all associated with proper management of your oral health.**

**Yes No Not Sure**

Are you in good health? \_\_\_\_\_  
Date of last medical examination \_\_\_\_\_  
Are you being treated by a physician now? \_\_\_\_\_  
Are you taking any drugs or medications? (Please list on next page) \_\_\_\_\_  
Do you take aspirin regularly? \_\_\_\_\_  
Have you had excessive bleeding requiring special treatment? \_\_\_\_\_

Have you ever had any of the following conditions?

- |                 |                     |                               |
|-----------------|---------------------|-------------------------------|
| Rheumatic Fever | Diabetes            | Heart Murmur or Valve Problem |
| Heart Disease   | Liver Problems      | Arthritis                     |
| Stroke          | Kidney Problem      | Asthma                        |
| Hepatitis       | High Blood Pressure | Bladder Problem               |
| Epilepsy        | Respiratory Problem | AIDS/HIV                      |
| Other _____     |                     |                               |
| Other _____     |                     |                               |

Are you allergic or unable to take any of the following drugs? (Check appropriate drugs)

- |                   |  |                |         |
|-------------------|--|----------------|---------|
| Local Anesthetics | Aspirin or Motrin                      | Antihistamines |         |
| (Novocaine)       | Penicillin                             | Demerol        | Codeine |
| Other Antibiotics | Sedatives/ Barbiturates/Sleeping Pills | Other Drugs    |         |

Please describe other problems: \_\_\_\_\_

Do you need to *Pre-Medicate* for your dental visits? \_\_\_\_\_

**Yes No Not Sure**

Has anyone in your family ever had diabetes? \_\_\_\_\_  
Have you ever had radiation treatments for a tumor or skin disease? \_\_\_\_\_  
Have you ever taken anti-coagulants? (Blood Thinner)? \_\_\_\_\_

Yes No Not Sure

If so, when and for how long? \_\_\_\_\_
Do you bruise easily? \_\_\_\_\_
Are you on a diet at this time? \_\_\_\_\_ Why? \_\_\_\_\_
Do you get out of breath easily? \_\_\_\_\_
Do you Smoke? \_\_\_\_\_ Packs per day \_\_\_\_\_
Do you have headaches regularly? \_\_\_ Mornings? \_\_\_ Evenings? \_\_\_
Women: Are you pregnant? \_\_\_\_\_
Do you take oral contraceptives? \_\_\_\_\_
Have you reached menopause? \_\_\_\_\_
Are you experiencing discomfort from your mouth at this time and if so, where? \_\_\_\_\_
How many times have you had your teeth cleaned in the last 5 years? \_\_\_\_\_
When was the last time? \_\_\_\_\_
Have you had previous periodontal treatment? \_\_\_\_\_ When? \_\_\_\_\_
Do your gums bleed? \_\_\_\_\_ When? \_\_\_\_\_ Where? \_\_\_\_\_
Have you noticed any loose teeth or shifting teeth? \_\_\_\_\_
Have you lost any teeth? \_\_\_ Why? \_\_\_ Have they been replaced
Any complications with extractions? \_\_\_\_\_
Have you noticed any mouth odors or bad tastes? \_\_\_\_\_
Are your teeth sensitive to heat, cold, or sweets? \_\_\_\_\_
Do foods wedge between your teeth? \_\_\_\_\_ Where? \_\_\_\_\_
How often do you brush your teeth? \_\_\_\_\_
Do you use: Dental Floss, toothpicks, rubber tip, stimudents, etc.? \_\_\_\_\_
Do you use a hard brush? \_\_\_ medium brush? \_\_\_ soft Brush? \_\_\_
How often do you replace your toothbrush? \_\_\_\_\_
Do you ever have fever blisters or cold sores on your lips? \_\_\_\_\_
Have you had your teeth straightened? \_\_\_\_\_
Are you satisfied with the appearance of your teeth? \_\_\_\_\_
Are you now under any increased nervous tension? \_\_\_\_\_
Are you aware of grinding or clenching your teeth? \_\_\_\_\_
When you chew, do you have clicking, popping or pain in jaw joints? \_\_\_

I authorize Dr. Schwartz and/or staff to perform necessary dental procedures.
I agree to be responsible for payment of dental services and materials.
I agree to be responsible for dental services and materials not payable
by my dental insurance plan.

Signature of Patient
Signature of Doctor
Date

Current Medications Dosage
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_

Arthur I. Schwartz, D.M.D., p.c. and Associates
Lakeside Office Park, Door 9, 599 North Avenue
Wakefield, MA 01880

**Insurance and Financial Information**

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Employer: \_\_\_\_\_

**Primary Dental Insurance Plan**

Subscriber: \_\_\_\_\_

Address: \_\_\_\_\_

*(If different from patient's)*

Date of Birth: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Address: \_\_\_\_\_

Employer (Group Name): \_\_\_\_\_

Address: \_\_\_\_\_

Group Number: \_\_\_\_\_ Subscriber ID Number: \_\_\_\_\_

**Secondary Dental Insurance Plan**

Subscriber: \_\_\_\_\_

Address: \_\_\_\_\_

*(If different from patient's)*

Date of Birth: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Address: \_\_\_\_\_

Employer (Group Name): \_\_\_\_\_

Address: \_\_\_\_\_

Group Number: \_\_\_\_\_ Subscriber ID Number: \_\_\_\_\_

**Medical Insurance Information**

Company: \_\_\_\_\_ Group Number: \_\_\_\_\_

Subscriber: \_\_\_\_\_ ID Number: \_\_\_\_\_

---

Arthur I. Schwartz. D.M.D., pc

# CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

---

## SECTION A: PATIENT GIVING CONSENT

Name: \_\_\_\_\_

## SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

**Purpose of Consent:** By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

**Notice of Privacy Practices:** You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

**Right to Revoke:** You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice.

## SIGNATURE

I, \_\_\_\_\_, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

**YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.  
Include completed Consent in the patient's chart.**