## Medical History Form

Name_____Date_____

Address_____

City_____State_____Zip Code_____

Date of Birth_____Social Security #_____

Phones: Home_____Work_____Cell_____

Email Address_____

Occupation_____Single___Married___Name of Spouse_____

Emergency Contact_____Relationship_____Phone_____

Primary Dentist/Who referred you to us?_____

INSURANCE: If you have dental insurance we will be happy to file your forms after treatment is performed.

Dental Insurance Company_____

| Health History (please check if you have any of the following) | |
|---|---|
| ❑ Yes ❑ No Are you in good health? | ❑ Yes ❑ No TB, Emphysema/ lung disease? |
| ❑ Yes ❑ No Has your health changed in the last year. | ❑ Yes ❑ No Diabetes? |
| ❑ Yes ❑ No Bleeding problems? | ❑ Yes ❑ No Hepatitis A, B, C |
| ❑ Yes ❑ No Headaches, ringing in ears? | ❑ Yes ❑ No Tumors, cancer? |
| ❑ Yes ❑ No Joint pain or arthritis? | ❑ Yes ❑ No Radiation treatment? |
| ❑ Yes ❑ No Fainting or seizures? | ❑ Yes ❑ No Psychiatric care? |
| ❑ Yes ❑ No Heart disease? | ❑ Yes ❑ No Kidney or bladder disease? |
| ❑ Yes ❑ No Rheumatic fever, murmurs, prosthetic heart valve? | ❑ Yes ❑ No V.D., herpes? |
| ❑ Yes ❑ No Pacemaker? | ❑ Yes ❑ No HIV positive (AIDS)? |
| ❑ Yes ❑ No High blood pressure? | ❑ Yes ❑ No Pregnant? month____ |
| ❑ Yes ❑ No Hepatitis or liver disease? | ❑ Yes ❑ No Birth control pills? |
| ❑ Yes ❑ No Anemia? | ❑ Yes ❑ No Do you smoke? _____per day |

List any allergies: (include medications)_____

_____

List all drugs/medications you are taking:_____

Pharmacy _____

- I authorize Dr. Weinstein to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Patient Signature_____Date_____

**David Weinstein D.M.D.**
136 East 64th Street
New York, New York 10065

# PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct and indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operation, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use of disclosure that occurred prior to the date I revoke this consent is not affected.

**PATIENT ACKNOWLEDGMENT**

By signing below, I hereby acknowledge that I have been provided with a copy of this office's Notice of Privacy Practices and have therefore been advised of how my protected health information may be used and disclosed by the office and how I may obtain access to and control this information. In addition, by signing below, I hereby consent to the use and disclosure of my health information for treatment purposes, payment activities and healthcare operations of the office as described in the Notice.

Signed this____day of_____, 20_____.

Print Patient Name:_____

Relationship to Patient:_____

Signature:_____