Robert W. Berg, DMD PC

Health History Form

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 questionaire 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.

Todays date: Referred by: Email:

Name: Home Phone: Work/Cell Phone:

Address: City: State: Zip:

Occupation: Height: Weight: Date of Birth:

SS#: Emergency Contact: Relationship: Contact #:

If you are completing this form for another person, what is you relationship to that person?

Dental History For the following questions, please mark (x) your responses to the following questions.

	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) treatment?	□	□	□
Have you had any problems associated with previous dental treatment?	□	□	□
Have you ever had an unpleasant bad odor in your mouth?	□	□	□
Do you drink bottled or filtered water?	□	□	□
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY	□	□	□
Are you currently experiencing dental pain or discomfort?	□	□	□

	Yes	No	DK
Do you have earaches or neck pains?	□	□	□
Do you have any clicking, popping or discomfort in the jaw?	□	□	□
Do you clench or grind your teeth?	□	□	□
Do you have sores or ulcers in your mouth?	□	□	□
Do your wear dentures or partials?	□	□	□
Have you ever had a serious injury to your head or mouth?	□	□	□
What is the reason for your visit today?			
Date of your last dental exam:			
What was done at that time?			
Date of last dental x-rays:			
How do you feel about your smile?			

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

	Yes	No	DK
Are you now under the care of a physician?	□	□	□
Physician Name: Phone:			
Address:			
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:			

	Yes	No	DK
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:			

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

(Check DK if you Don't Know the answer to the question)	Yes	No	DK
Do you wear contact lenses?	□	□	□
Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? Date: _____If yes, have you had any complications? _____	□	□	□
Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risendronate (Actonel®) 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, hypercalecemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? Date treatment began: _____	□	□	□

	Yes	No	DK
Do you use controlled substances?	□	□	□
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 hours? _____ If yes, how much do you typically drink in a week? _____	□	□	□

WOMEN ONLY - Are you:	Yes	No	DK
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.

	Yes	No	DK
Local anesthetics _____	□	□	□
Aspirin _____	□	□	□
Penicililn or other antibiotics _____	□	□	□
Barbituates, 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 had or have not had any of the following diseases or problems.

	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	□	□	□

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

	Yes	No	DK
Cardiovascular disease	□	□	□
Angina	□	□	□
Arteriosclerosis	□	□	□
Congestive heart failure	□	□	□
Damaged heart valves	□	□	□
Heart attack	□	□	□
Heart murmur	□	□	□
Low blood pressure	□	□	□
High blood pressure	□	□	□
Other congenital heart defects	□	□	□
Mitral valve prolapse	□	□	□
Pacemaker	□	□	□
Rheumatic fever	□	□	□
Rheumatic heart disease	□	□	□
Abnormal bleeding	□	□	□
Anemia	□	□	□
Blood transfusion If yes, date: _____	□	□	□
Hemophilia	□	□	□
AIDS or HIV infection	□	□	□

	Yes	No	DK
Arthritis	□	□	□
Autoimmune disease	□	□	□
Rheumatoid arthritis	□	□	□
Lupus	□	□	□
Asthma	□	□	□
Bronchitis	□	□	□
Emphysema	□	□	□
Sinus trouble	□	□	□
Tuberculosis	□	□	□
Cancer/Chemotherapy/ Radiation Treatment	□	□	□
Chest pain	□	□	□
Chronic pain	□	□	□
Diabetes Type I Type II	□	□	□
Eating disorder	□	□	□
Malnutrition	□	□	□
Gastrointestinal disease	□	□	□
G.E. Reflux/heartburn	□	□	□
Ulcers	□	□	□
Thyroid problems	□	□	□
Stroke	□	□	□
Glaucoma	□	□	□
Hepatitis, jaundice, or liver disease	□	□	□
Epilepsy	□	□	□
Fainting spells/ seizures	□	□	□
Neurological disorder If yes, specify _____	□	□	□
Mental health disorder Specify: _____	□	□	□
Recurrent infections Type of infection: _____	□	□	□
Kidney problems	□	□	□
Night sweats	□	□	□
Osteoporosis	□	□	□
Swollen glands	□	□	□
Headaches/migraines	□	□	□
Severe or rapid weight loss	□	□	□
STD's	□	□	□
Excessive urination	□	□	□

	Yes	No	DK
Has a physician or previous dentist recommended that you take antibiotics prior to dental treatment?	□	□	□

Name of physician or dentist making recommendation: Phone:

	Yes	No	DK
Do you have any disease, condition, or problem not listed above that you think I should know about? Please explain:	□	□	□

NOTE: You are encouraged to discuss any and all of your relevant health issues with Dr. Berg 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 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:

ROBERT W. BERG, DMD PC

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The health Insurance Portability and Accountability Act of 1996 (HIPPA) requires that health providers keep your medical and dental information private. The HIPPA privacy rule states that health providers must also provide patients with a written Notice of Privacy Practices. This notice is dated January 2008. The Privacy Practices described will be in effect after this date and until or if they are replaced. You may obtain additional copies of this Notice upon request.

Uses and Disclosure of Information

Treatment Services
We may use or provide you health information to all of our staff members, other dentists, your physicians, and/or other healthcare providers taking care of you. We may also provide mail, phone or electrical contact as appointment reminders, recommendations of treatment alternatives, information about other health services and/or other office services.

Payment and Operations
We may provide your health information as required to allow for payment for services and participation in quality assurance, disease management, training, licensing, and certification programs.

Marketing
We will not use your health information for marketing purposes without your written consent.

Legal Requirements
We may disclose your health information when required by law.

Threat to Health and Safety
If abuse or neglect is reasonable, we may disclose your health information to the appropriate governmental authorities.

National Security
When required, we may disclose military personnel with health information to the Armed Forces. Information may be given to authorized federal officials when required for intelligence and national security.

Family Members, Friends, and Others Involved in Care
At your request, we may disclose your health information to a family member or other person if necessary to assist with your treatment and/or payment for services. Based on our judgement and as per 164.522(a) of HIPAA we may disclose your information to these persons in the event of an emergency situation. We also may make information available so that another person may pick up filled prescriptions, medical supplies, records, or x-rays for you. Your information may be disclosed to assist in notifying a family member, care-giver, or personal representative of your location or condition.

Patient Rights
You have the right to see your information and receive copies of your records under most circumstances. Your request must be in writing, addressed to the contact officer. You may be charged for the cost of making copies including the actual copies and staff time. Postage will be added if copies are requested to be mailed. A summary of your health information can also be requested for a fee.

You may request a listing of any situations where we or our business associates disclosed your health information for purposes other than treatment, payment, or other activities for the last six years. You may be charged for costs associated with our response.

You may request that we observe additional restrictions on the disclosure of your information. We are not required to agree to these restrictions, but we may do so (except in case of an emergency).

If you believe that changes should be made to your health information, you must request this in writing. You must provide an explanation as to why changes should be made. Even with your request, changes may be refused under certain circumstances.

If you would like to receive your health information in an alternate format or at a specified location you must make your request in writing.

Acknowledgement of Receipt of Notice of Privacy Practices

By signing this form I confirm that I have had the opportunity to receive a copy of the Notice of Privacy Practices.

PRINT NAME _____

SIGN NAME _____ DATE _____