

DENTAL Medical History Form

Date _____

Name _____ Home Phone () _____
Last First Middle

Address _____ Business Phone () _____
Number, Street

City _____ State _____ Zip Code _____

Occupation _____ Social Security No. _____

Date of Birth ____ / ____ / ____ Sex M F Height _____ Weight _____ Single _____ Married _____
mo. day yr.

Name of Spouse _____ Closest Relative _____ Phone () _____

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

Referred by _____

For the following questions, *circle yes or no*, whichever applies. Your answers are for our records only and will be considered confidential. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health.

- | | | |
|--|-----|----|
| 1. Are you in good health? | Yes | No |
| 2. Has there been any change in your general health within the past year? | Yes | No |
| 3. My last physical examination was on _____ | Yes | No |
| 4. Are you now under the care of a physician? | Yes | No |
| If so, what is the condition being treated? _____ | | |
| 5. The name and address of my physician(s) is _____ | | |
| _____ | | |
| 6. Have you had any serious illnesses, operation, or been hospitalized in the past 5 years? | Yes | No |
| If so, what was the illness or problem? _____ | | |
| 7. Are you taking any medicine(s) including non-prescription medicine? | Yes | No |
| If so, what medicine(s) are you taking? _____ | | |
| 8. Do you have or have you had any of the following diseases or problems? | Yes | No |
| a. Damaged heart valves or artificial heart valves, including heart murmur or rheumatic heart disease | Yes | No |
| b. Cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke) | Yes | No |
| 1. Do you have chest pain upon exertion? | Yes | No |
| 2. Are you ever short of breath after mild exercise or when lying down? | Yes | No |
| 3. Do your ankles swell? | Yes | No |
| 4. Do you have inborn heart defects? | Yes | No |
| 5. Do you have a cardiac pacemaker? | Yes | No |
| c. Allergy | Yes | No |
| d. Sinus trouble | Yes | No |
| e. Asthma or hay fever | Yes | No |
| f. Fainting spells or seizures | Yes | No |
| g. Persistent diarrhea or recent weight loss | Yes | No |
| h. Diabetes | Yes | No |
| i. Hepatitis, jaundice or liver disease | Yes | No |
| j. AIDS or HIV infection | Yes | No |
| k. Thyroid problems | Yes | No |
| l. Respiratory problems, emphysema, bronchitis, etc. | Yes | No |
| m. Arthritis or painful swollen joints | Yes | No |
| n. Stomach ulcer or hyperacidity | Yes | No |
| o. Kidney trouble | Yes | No |
| p. Tuberculosis | Yes | No |
| q. Persistent cough or cough that produces blood | Yes | No |
| r. Persistent swollen glands in neck | Yes | No |
| s. Low blood pressure | Yes | No |
| t. Sexually transmitted disease | Yes | No |
| u. Epilepsy or other neurological disease | Yes | No |
| v. Problems with mental health | Yes | No |
| w. Cancer | Yes | No |
| x. Problems of the immune system | Yes | No |

9. Have you had abnormal bleeding? Yes No
 a. Have you ever required a blood transfusion? Yes No
 10. Do you have any blood disorder such as anemia? Yes No
 11. Have you ever had any treatment for a tumor or growth? Yes No
 12. Are you allergic or have you had a reaction to: Yes No
 a. Local anesthetics Yes No
 b. Penicillin or other antibiotics Yes No
 c. Sulfa drugs Yes No
 d. Barbiturates, sedatives, or sleeping pills Yes No
 e. Aspirin Yes No
 f. Iodine Yes No
 g. Codeine or other narcotics Yes No
 h. Other Yes No
 13. Have you had any serious trouble associated with any previous dental treatment? Yes No
 If so, explain _____
 14. Do you have any disease, condition, or problem not listed above that you think I should know about? Yes No
 If so, explain _____
 15. Are you wearing contact lenses? Yes No
 16. Are you wearing removable dental appliances? Yes No
- Women**
 17. Are you pregnant? Yes No
 18. Do you have any problems associated with your menstrual period? Yes No
 19. Are you nursing? Yes No
 20. Are you taking birth control pills? Yes No

Chief Dental Complaint _____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

 Signature of Patient

For completion by the dentist.

Comments on patient interview concerning medical history: _____

Significant findings from questionnaire or oral interview: _____

Dental management considerations: _____

 (Date)

 Signature of Dentist

Medical history update:

Date	Comments	Signature
_____	_____	_____
_____	_____	_____
_____	_____	_____

MEDICATION ALERT

Patient Number: _____

Patient Name: _____

Page # _____

1. **PREMEDICATION:** Yes No
 Type Recommended:

2. **ALLERGIES:**

3. Complete list of current medications, including both prescription and over-the-counter:

	Start Date	End Date		Start Date	End Date
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

4. Updated:

Date	Initials	Date	Initials	Date	Initials
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

CONSENT TO TREATMENT

please print

Patient Name						
Address	Number & Street		Town/City		State	Zip Code
Date of Birth	Height	Weight	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status	Occupation	

- I authorize the performance on _____ of the dental treatment plan as explained to me by _____ (state "myself" or name of patient)
- The foreseeable material risks* and benefits of the accepted treatment plan have been explained, and I fully understand them.
- Alternative treatment plans have been presented, and explained to me including their benefits and foreseeable risks.
- I also understand that in the provision of dental treatment, oral conditions may be photographed, and I consent to this as long as my identity is not revealed. I understand that these photographs may be used for medical documentation, teaching, research or scientific publication. I also understand that other members of the dental and/or medical profession may be present as observers.
- I understand that the practice of dentistry/medicine is not an exact science, and I acknowledge that I have received no guarantees or assurances about the outcome of treatment or any of its components, benefits or results.
- I understand that changes in the accepted treatment plan may be necessary during the course of treatment, and I will be informed of these changes.
- I fully understand that a specific dental procedure may be referred to another general dentist or specialist in another dental clinic.
- I have been given the opportunity to ask questions and my questions have been answered to my satisfaction.
- I have read this entire consent to treatment, and fully understand the conditions of this consent and have no additional questions.

*Foreseeable risks are those that other practitioners in the community tell their patients in similar situations.

SUPPLEMENT FOR PERSONS UNDER 18 INTENDING TO CONSENT FOR THEMSELVES Check Yes or No as appropriate. To be completed by patient who has not reached his or her birthday and wishes to consent to treatment:

- Age at last birthday.....
- Are you now or have you ever been married?.... Yes No
- Are you now or have you ever been a parent?... Yes No
- Are you now in the armed forces?..... Yes No
- For females: Are you pregnant?..... Yes No
- Are you self-supporting?..... Yes No

*Question 6 need not be answered if the answer to questions 2, 3, 4 or 5 is yes.

Furthermore, the cost of treatment, as listed at right, has been explained to me and I agree to pay the fee, in whole or in part, as it becomes due and owing.

I understand that treatment modifications may be required as treatment progresses and that the fee may need to be modified to reflect those changes. I further understand that, whenever possible, I will be informed of any changes as the need to them becomes apparent.

CATEGORY OF SERVICE	FEE (EST)
1. Diagnostic	
2. Operative	
3. Periodontics	
4. Oral Surgery	
5. Endodontics	
6. Oral Pathology	
7. Fixed Prosthesis	
8. Removable Prosthesis	
9. Other	
Fee- Total Care Sum of lines 1-9	

CONSENT TO TOTAL CARE & FEE

_____	_____
Signature of Patient or Legal Representative	Date

CATHOLIC CHARITIES HEALTH SYSTEMS
of the Diocese of Rockville Center Inc. (CCHS)
DIAGNOSTIC AND TREATMENT CENTER
Special Dental Services (SDS)

PATIENT AGREEMENT

I, _____, or my legal designate have consented to dental treatment by the Special Dental Services, and will hereby abide by the regulations set forth by Catholic Charities Health Systems governing the use of the facilities at 333 North Main in Freeport.

I understand that Catholic Charities Health Systems is a smoke-free environment, and that smoking is not allowed on the premises, with the exception of the smoking room accessible only to clients of the Adult Day Health Care Services.

I also understand that substance usage on the premises will not be tolerated. While neither the Adult Day Health Care Services or the Special Dental Services exclude persons solely on the basis of their substance use, Catholic Charities Health Systems does expect all clients to adhere to the following policies:

1. No substance usage on site.
2. No access to any services while under the influence of any non-prescribed substance.
3. No selling or sharing of any substance with another patient/client at the facility.

I understand that failure to adhere to these policies may result in either postponement of treatment, or possible termination from the Special Dental Services.

I further understand that physical violence or threat of violence will result in suspension of treatment on the day that it occurs, as well as for a period of time to be determined at the time of the incident. Possession or use of a weapon of any kind will result in immediate termination from the Special Dental Services. I further understand that any question of child abuse or neglect will be reported to the appropriate authorities as mandated by the State of New York.

State and federal laws shall govern all questions concerning the construction, validity, and interpretation of this Agreement and the performance of the obligations imposed by this Agreement.

In compliance with New York State laws, federal laws, and Catholic Charities Health Systems standards, no person shall be discriminated against on the basis of race, color, creed, sex, religion, national origins, sexual orientation, citizenship status, marital status, or disability. Catholic Charities Health Systems admits and treats all clients on this non-discriminatory basis.

I, the undersigned, have read the above, and I assume the responsibility to abide by all of the provisions above.

I have also received a copy of the Patient's Bill of Rights.

Patient Name (Print)

Patient Signature

Date

Witness Name (Print)

Witness Signature

Date

CATHOLIC CHARITIES HEALTH SYSTEMS
of the Diocese of Rockville Center Inc. (CCHS)
DIAGNOSTIC AND TREATMENT CENTER
Special Dental Services (SDS)

PATIENT CONFIDENTIALITY AND DISCLOSURE FORM

I, _____, or my legal designate authorize the CCHS Special Dental Services through its staff of dental professionals and trained dental auxiliaries to provide me with all dental treatment which may be deemed necessary by the SDS dentist. I understand that I will be fully informed as to the nature and necessity of treatment, and the possible consequences of either dental treatment or my electing not to be treated, for each procedure proposed. I fully understand that if I elect not to consent to a specific dental procedure I will be required to sign a statement to that effect which will be placed in my dental records.

I give SDS permission to contact on my behalf the following individuals and agencies if requested: dentists, physicians, practitioners, AIDS-designated treatment centers or general hospitals, health clinics, pharmacies, Medicaid, ADAP or other social service agencies such as the Long Island Association for AIDS Care and/or the Persons With AIDS Coalition. More specifically I give you permission to contact the following individuals and agencies: oral surgeons, periodontists, endodontists, personal physician and/or case manager.

I understand that all SDS staff are required to keep all information related to my treatment and my identity strictly confidential. I also understand, however, that when I am referred to another dentist or medical practitioner, the SDS dentist may disclose my HIV status to that practitioner if he/she feels that there is medical necessity to do so. I understand that I will be apprised of that disclosure.

I fully realize that while my confidentiality will be strictly observed by SDS staff, the very fact that I am being treated by the SDS dentist may in itself indicate to others my HIV status, as it has become known that SDS only treats persons who are HIV seropositive. I in no way hold SDS responsible for any breach of my confidentiality which is caused solely by another person's awareness that I am a patient of SDS.

PATIENT: _____

SIGNED: _____

WITNESS: _____

DATE: _____

CATHOLIC CHARITIES HEALTH SYSTEMS

SPECIAL DENTAL SERVICES

Registration Date: _____ Patient Number: _____

Please print legibly and provide all information requested.

Name: _____ Sex: _____
Last First M.I.

Social Security #: _____ Driver's License #: _____ State: _____

Date of Birth: _____ Adult or Child Birthplace: _____

LOCAL ADDRESS

PERMANENT ADDRESS

Street _____

Street _____

City State Zip _____

City State Zip _____

Home Phone Business Phone _____

Home Phone Business Phone _____

Other names by which you are or have been known: _____

Have you been previously treated by YES Emergency Care
Catholic Charities Special Dental Services? NO, If yes, for _____ Routine Care Date last treated _____

Person responsible for payment: Name _____ Social Security # _____

Relation to Patient: _____ Driver's License #: _____ State: _____

Address _____
Street City State Zip

Telephone: Home _____ Business _____

Employer _____ Occupation _____

Parent or Guardian (if patient is a minor) _____

Address _____
Street City State Zip

Telephone: Home _____ Business _____

Employer _____ Occupation _____

Emergency Contact: _____

Telephone Number: _____ Relation to Patient: _____

Payment Information: Self-Pay Current Medicaid # _____ Seq. # _____
 Third Party will reimburse patient ADAP # _____

Patients' Bill of Rights

As a patient in a health care facility in New York State,
you have the right, consistent with law, to:

- (1) Understand and use these rights. If for any reason you do not understand or you need help, the health care facility **MUST** provide assistance, including an interpreter.
- (2) Receive treatment without discrimination as to race, color, religion, sex, national origin, disability, sexual orientation or source of payment.
- (3) Receive considerate and respectful care in a clean and safe environment free of unnecessary restraints.
- (4) Receive emergency care if you need it.
- (5) Be informed of the name and position of the dentist who will be in charge of your care.
- (6) Know the names, positions and functions of any staff involved in your care and refuse their treatment, examination or observation.
- (7) A no smoking room.
- (8) Receive complete information about your diagnosis, treatment and prognosis.
- (9) Receive all the information that you need to give informed consent to any proposed procedure or treatment. This information shall include the possible risks and benefits of the procedure or treatment.
- (10) Receive all the information you need to give informed consent for an order not to resuscitate. You also have the right to designate an individual to give this consent for you if you are too ill to do so. If you would like additional information, please ask for a copy of the pamphlet "Do Not Resuscitate Orders - A Guide for Patients and Families."
- (11) Refuse treatment and be told what effect this may have on your health.
- (12) Refuse to take part in research. In deciding whether or not to participate, you have the right to a full explanation.
- (13) Privacy while in the dental clinic and confidentiality of all information and records regarding your care.
- (14) Participate in all decisions about your treatment and discharge from the clinic. The dental clinic must provide you with a written discharge plan and written description of how you can appeal your discharge.
- (15) Review your dental record without charge. Obtain a copy of your dental record for which the dental clinic can charge a reasonable fee. You cannot be denied a copy solely because you cannot afford to pay.
- (16) Receive an itemized bill and explanation of all charges.
- (17) Complain without fear of reprisals about the care and services you are receiving and to have the dental clinic respond to you and if you request it, a written response. If you are not satisfied with the response, you can complain to the New York State Health Department. The dental clinic must provide you with the Health Department telephone number.
- (18) Authorize those family members and other adults who will be given priority to visit consistent with your ability to receive visitors.