CONFIDENTIAL MEDICAL HISTORY

Present reason for dental visit:_____

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

Address:_____ Date of Birth:_____ Age_____

City: _____State: _____ Zip:_____

Home Phone:_____Cell/Pager#_____

Employer _____ Work Phone: _____

Referred By _____ Parent or Legal Guardian (under 18)_____

Date of last cleaning or checkup:_____ Previous Dentist :_____

Name of Medical Doctor:_____ Phone # :_____

Please respond YES or NO if you have ever experienced any of the following conditions:

	Yes	No		Yes	No
Mitral Valve Prolapse	____	____	Radiation Treatment	____	____
Heart Murmur	____	____	Tuberculosis	____	____
Rheumatic Fever	____	____	Hepatitis	____	____
Artificial Valve	____	____	Asthma	____	____
Artificial Joints	____	____	Hemophilia	____	____
AIDS	____	____	Epilepsy	____	____
Kidney Disease	____	____	Venereal Disease	____	____
Stroke	____	____	Pacemaker	____	____
Diabetes	____	____	Arthritis	____	____
High Blood Pressure	____	____	Heart Disease	____	____
Heart Attack	____	____	Chemotherapy	____	____
Cancer	____	____	Females / pregnant	____	____
Please specify:_____			Due Date:_____		

Medications you are presently taking (including oral contraceptives)_____

_____

Allergies to: Antibiotics_____ Latex_____

Pain Medications_____ Other_____

List any other existing conditions or illnesses_____

Are you a smoker?_____ If yes, # of packs/day_____

The health history above is accurate to the best of my knowledge.

Signature (Parent/Guardian if under 18 years):_____ Date:_____

Medical History Updated

Signature:_____ Date:_____

Signature:_____ Date:_____

Signature:_____ Date:_____

Signature:_____ Date:_____

HILLVIEW DENTAL

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient #: _____ Social Security #: _____

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:

Contact Person: Dr David Stasiak

Telephone: (716) 681-5468 Fax: (716) 706-1106

E-mail: DrStaze@aol.com

Address: 6347 Transit Road, Depew NY 14043

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.

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.

HILLVIEW DENTAL

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowedgement*

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 acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____