Name_____
Last First M. In.

Residence_____ Date of Birth_____ Home Phone_____

PATIENT MEDICAL HISTORY

Name of personal physician_____ Office Phone_____

Address of personal physician_____

Approximate date of last physical examination_____. May we contact your physician regarding your health? ..... Yes No

1. Are you undergoing any medical treatment now? ..... Yes No
2. Have you had any major operations? If so what? ..... Yes No
3. Have you ever had a serious accident involving head injuries? ..... Yes No
4. Have you had any adverse response to any drugs including penicillin? If you have please list drugs on reverse side. ..... Yes No
5. Circle any of the following which you have had or have at present.

Heart Failure	Stroke	Blood Diseases	Yellow Jaundice	Heart Pacemaker
Heart Disease or Attack	Anemia	Scarlet Fever	HIV Positive	Heart Surgery
Angina Pectoris	Ulcers	Chronic Headache	Blood Transfusion	Heart Murmur
High Blood Pressure	TMJ/TMD	Allergies or Hives	Drug Addiction	Emphysema
Venereal Disease (Syphilis, Gonorrhea)	AIDS	Rheumatism	Hemophilia	Sinus Trouble
Rheumatic Fever	Cough	Artificial Joint	Cortisone Medicine	Diabetes
Congenital Heart Problems	Bruise	Thyroid Disease	Tuberculosis (TB)	Liver Disease
Chemotherapy (Cancer, Leukemia)	Asthma	Pain in Jaw Joints	Epilepsy of Seizures	Kidney Trouble
Artificial Heart Valve	Hay Fever	Hepatitis A (infectious)	Fainting or Dizzy Spells	Cold Sores
X-Ray Cobalt Treatment	Glaucoma	Hepatitis B (serum)	Sickle Cell Disease	Nervousness
Headaches at regular intervals	Arthritis	Hepatitis C	Psychiatric Treatment	Mitral Valve Prolapse
Malignancies				

6. Are you on a diet at this time? ..... Yes No
7. Are you now taking drugs or medications? (Please list any medications you are taking on the back of this form.) ..... Yes No
8. Are you allergic to any known materials or medication resulting - in hives, asthma, eczema, etc ..... Yes No
9. Are you in general good health at this time? ..... Yes No
10. Have any wounds healed slowly or presented other complications? ..... Yes No
11. Do you smoke? ..... Yes No
12. For Women: Are you pregnant? or do you think you may be pregnant? ..... Yes No
13. For Women: Are you presently taking birth control pills? ..... Yes No
14. Do you consume more than 3 oz. of alcohol per day? ..... Yes No
15. Do you have a history of fainting? ..... Yes No
16. Have you ever had any X-RAY TREATMENTS (other than diagnostic)? ..... Yes No
17. Have you ever taken the appetite suppressant drug PONDIMIN (fenfluramine) or REDUX (dexphenfluramine)? ..... Yes No
18. Have you ever taken or been administered any medication considered to be a bisphosphonate; such as but not limited to: risedronate sodium (chemical name) **ACTONEL** (brand name) by Procter & Gamble/Aventis, alendronate sodium (chemical name) **FOSAMAX** (brand name) by Merck, pamidronate disodium (chemical name) **AREDIA** (brand name) by Novartis, zoledronic acid (chemical name) **ZOMETA** (brand name) by Novartis? ..... Yes No

PATIENT DENTAL HISTORY

Approximate date of last dental examination_____

Treatment done at last dental appointment_____

May we request your previous dental records? ..... Yes No

Name of previous dentist?_____

1. Do you have pain in or near your ears? Or ringing in your ears? ..... Yes No

Continued on next page

2. Do you have any unhealed injuries of inflamed areas in or around your mouth? ..... Yes No
3. Have you experienced any growth or sore spots in your mouth? ..... Yes No
4. Does any part of your mouth hurt when clenched? ..... Yes No
5. Have you ever had a local dental anesthetic administered to you? ..... Yes No
6. Have you ever had any reactions or allergic symptoms to any local anesthetic? ..... Yes No
7. Have you ever had any difficult extractions in the past?. ..... Yes No
8. Have you ever had any prolonged bleeding following extractions in the past? ..... Yes No
9. Have you ever had Trench Mouth? ..... Yes No
10. Do your gums bleed? ..... Yes No
11. Have you ever had instruction on the correct method of brushing your teeth? ..... Yes No
12. Have you ever had instructions on the care of your gums? ..... Yes No
13. Have you ever been treated for periodontal disease? ..... Yes No
14. Do you chew on only one side of your mouth? If so why? ..... Yes No
15. Do you at the present time have any dental complaints? ..... Yes No
16. Do you clench or grind your teeth during the night or day? ..... Yes No
17. When was your last full mouth X-RAY taken? ..... Date: _____
18. Is any part of your mouth or are any or your teeth sensitive to pressure, cold/hot, sweets, touch, brushing, etc. ..... Yes No
19. If so which teeth or what areas _____

Do you have or have you had any of the following?

Dentures	Yes	No	Loose or broken fillings	Yes	No
Food impaction	Yes	No	Burning tongue	Yes	No
Swelling in mouth	Yes	No	Unpleasant taste	Yes	No
Lump in your mouth	Yes	No	Tired jaws	Yes	No
Lip or mouth blishers	Yes	No	Many cavities	Yes	No
Bad breath	Yes	No	Teeth sensitive to cold	Yes	No
Gag easily	Yes	No	Gum treatments	Yes	No
Teeth straightened	Yes	No	Mouth breathing	Yes	No
Loose teeth	Yes	No	Sounds in ear when chewing	Yes	No
Does your jaw pop or click	Yes	No			

How often do you brush your teeth? _____ Floss? _____

Are you dissatisfied with the alignment of your teeth? ..... Yes No

Are you very apprehensive about receiving dental treatment? ..... Yes No

Do you experience pain when in contact with any of the following?

Hot foods or liquids	Yes	No	Cold foods or liquids	Yes	No
Sweet foods or liquids	Yes	No	Sour foods or liquids	Yes	No

What prompted you to seek dental care at our office? _____

_____

_____

We would like to thank you for taking the time to fill out this boring Medical/Dental Health History Form. As trival and non applicable to your dental concerns as some questions may seem to you, your respnses to the questions provide us with the necessary information to provide you with the optimal dental care you expect from us.

Date_____ Patient's/Guardian's Signature_____

Date_____ Dentist's Signature _____

Saavedra Family Dental, PC

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Saavedra Family Dental to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by Saavedra Family Dental describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Saavedra Family Dental reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Saavedra Family Dental at 185 N Wantagh Avenue Levittown, NY 11756 phone (516) 622-9394

With this consent, Saavedra Family Dental may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Saavedra Family Dental may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

By signing this form, I am consenting to allow Saavedra Family Dental to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Saavedra Family Dental may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____ _____
Print Patient's Name Date

_____
Print Name of Patient or Legal Guardian, if applicable

Saavedra Family Dental

Tania Saavedra, DDS
185 N Wantagh Avenue
Levittown, NY 11756
(516) 622- 9394

Patient Information Form

*Please make sure to read, sign, and date the back of this form.

Patient Full Name (First, Middle, Last)

Employer

Street Address

Is a member of your family a patient in our office?
If so, please list their name.

City | State | Zip Code

Home Phone | Work Phone | Cell Phone

Date of Birth | Social Security Number

☐Single ☐ Married

☐Divorced ☐Widowed | E-Mail Address

If filling out paperwork for your child:

Parent/Legal Guardian

Address, if different from your child

City | State | Zip Code

PLEASE LIST TWO

Emergency Contact Name

Emergency Contact Address

Home Phone | Work Phone | Cell Phone

Emergency Contact Name

Emergency Contact Address

Home Phone | Work Phone | Cell Phone

INSURANCE INFORMATION

Subscriber's Full Name

Group/Employer's Name

Dental Insurance Company

Subscriber's ID #

Subscriber's SSN

Dental Insurance Address

Group Number

Effective Date

City

State

Zip Code

Customer Service Number

Date of Birth

OFFICE POLICIES & FEDERAL TRUTH-IN-LENDING STATEMENT

A payment is expected at the time of your appointment. Patients with a co-payment must pay at the time of the appointment. Patients must pay their account IN FULL at the time of service unless you set up a payment plan with our office credit manager. If you have dental insurance we will send out claim forms as a service to you to your insurance company. It is your responsibility to make sure we have all of the correct information. Patients are responsible for any balances after the insurance payment is received.

A service charge of 1.5% per month (18%annually) on the unpaid balance will be assessed on all accounts exceeding sixty days from the date of service. Fee estimates for dental care can only be extended for six months from the date of the patient examination.

In consideration for the professional services rendered to me, (or at my request, to my minor child or ward) by the dentist, I agree to pay the fees charged for the dental services provided by the dentist or licensed employee at the time the services are rendered, or within five days of billing if credit is extended by the dentist. In the event my account becomes delinquent, I agree to pay the remaining balance plus the sum of the collection agency commission of 40% of the delinquent balance if the account is turned for collection, in addition to reasonable attorney fees and court costs where such legal services are necessary. I authorize the release of financially identifiable information concerning my account, including charges billed, payments made, and interest charges assessed, etc. to the dentist's collection agency or collection attorney should collection procedures as described become necessary.

I grant my permission to you or your assignee to telephone me at home or at my workplace to discuss matters related to this form. I also agree to let the office leave messages concerning appointments and/or results on my answering machine or with a family member.

I authorize the dentist or his designees to release financially identifiable information and treatment descriptions and information, either electronically, by facsimile or in paper form to my insurance carrier or any related entities that require such information to be submitted.

I authorize assignments or payment of all dental and/or surgical benefits to which I or other family members are entitled, including private dental insurance and other group health plan benefits otherwise payable to the undersigned, to Dr. Tania Saavedra.

I acknowledge that I have received a copy of this office's Privacy Policies. I agree to disclose to the dentist names of any individuals with whom I authorize the dentist to discuss my dental care.

I certify that I have answered all questions on the form accurately. I hereby agree to abide by the conditions outlined there in.

X_____

Signature of Patient/Legal Guardian Date