KASPEROWSKI

FAMILY DENTISTRY

79 BROAD STREET • WESTFIELD, MA 01085 • TELEPHONE: 413-562-5494

Date:

PATIENT INFORMATION

First Name: _____ Last Name: _____

Birth Date: _____

SSN: _____

Address: _____ Apt. #: _____

City: _____ State: _____ Zip: _____

Home Phone: _____

Cell: _____

Email: _____

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79 Broad Street • Westfield, MA 01085 • Phone: 413-562-5494 • Fax: 413-568-5597

Date:

Health History

Name of your physician?

Date of last dental/dental hygene visit?

Medical History

1. Are you under medical treatment now? ☐ Yes ☐ No
2. Have you ever been hospitalized for any surgical operation or serious illness? ☐ Yes ☐ No
3. Are you taking any medication(s) including non-prescription medicine? ☐ Yes ☐ No

If yes, what medication are you taking?

4. Do you use tobacco? ☐ Yes ☐ No
5. Do you use alcohol? ☐ Yes ☐ No
6. Do you use cocaine or other drugs? ☐ Yes ☐ No
7. Are you wearing contact lenses? ☐ Yes ☐ No

PLEASE ONLY CHECK BOXES THAT APPLY

8. Are you allergic to or have you had any reactions to the following?

Aspirin	☐	Penicillin or other antibiotics	☐
Barbiturates	☐	Sedatives	☐
Iodine	☐	Sulfa drugs	☐
Local anesthetics (e.g. Novocain	☐	Other	

9. Women only:
   a. Are you pregnant or think you may be pregnant? ☐
   b. Are you nursing? ☐
   c. Are you taking birth control pills? ☐
10. Do you have or have you had any of the following?

AIDS or HIV infection	☐	High blood pressure	☐
Angina	☐	Kidney diseases	☐
Asthma	☐	Joint replacement or implant	☐
Arthritis	☐	Leukemia	☐
Cancer	☐	Liver disease	☐
Cardiac pacemaker	☐	Low blood pressure	☐
Chest pain	☐	Radiation therapy	☐
Diabetes	☐	Recent weight loss	☐
Easily winded	☐	Respiratory problems	☐
Emphysema	☐	Rheumatic fever	☐
Epilepsy/Convulsions	☐	Sexually transmitted diseases	☐
Glaucoma	☐	Stomach troubles/Ulcers	☐

Hay fever/Allergies	☐	Stroke	☐
Heart attack	☐	Swollen ankles	☐
Heart diseases	☐	Thyroid problem	☐
Heart murmur	☐	Tuberculosis	☐
Heart trouble	☐	Other	
Hepatitis/Jaundice	☐		

Dental History

1. Do your gums bleed while brushing or flossing? ☐
2. Are your teeth sensitive to hot or cold liquid? ☐
3. Are your teeth sensitive to sweet or sour liquid/food? ☐
4. Do you feel pain in any of your teeth? ☐
5. Do you have any sores or lumps in or near your mouth? ☐
6. Have you had any head, neck or jaw injuries? ☐
7. Have you ever experienced any of the following?
   - a. Clicking? ☐
   - b. Pain (joint, ear, side of face)? ☐
   - c. Difficulty in opening or closing? ☐
   - d. Difficulty chewing? ☐
8. Do you have frequent headaches? ☐
9. Do you clench or grind your teeth? ☐
10. Do you bite your lips or cheeks frequently? ☐
11. Have you had any difficult extractions in the past? ☐
12. Have you had any orthodontic work? ☐
13. Have you had any prolonged bleeding following extractions? ☐
14. Have you ever had instruction on the correct method of brushing your teeth? ☐
15. Have you ever had instructions on the care of your gums? ☐

Current oral condition

1. How often do you brush your teeth?

2. How often do you floss your teeth?

3. What oral aids do you routinely use at home?

4. Do you want to keep your natural teeth? ☐
5. Do you have complete dentures/partial dentures/fixed bridges/implants? ☐
6. Do you clean your dental appliances? ☐
7. Do you breathe through your mouth? ☐
8. Do you favor one side of your mouth? ☐
9. What do you want to change about your oral condition?

I have read my History and confirm that it adequately reflects past and present conditions.

Authorized signature of covered person (For minor, Parent or Guardian)

Patient/Guardian Signature

Reviewing Dr. Signature

KASPEROWSKI FAMILY DENTISTRY

(NAME OF PRACTICE)

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____ SS # _____

Address: _____

Telephone: _____ E-mail: _____

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: **Bryan Kasperowski**

Telephone: **(413) 562-5494** Fax: **(413) 568-5597**

Address: **79 Broad Street, Westfield, MA 01085**

Email: **reception@drkasperowski.com**

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 the Consent.

Cell Phone Use Policy

1. ☐ I provide consent to Kasperowski Family Dentistry to use my cell phone number to (choose one or both)

☐ call or ☐ text regarding appointments

2. ☐ I consent to Kasperowski Family Densitry to call using my cell phone regarding treatment, insurance, and my account. I understand that I can withdraw my consent at any time. My cell phone number (include area code)

_____ _____ (Initial)

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of the Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, that 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 THE CONSENT AFTER YOU SIGN IT.

Include completed Consent in the patient's chart.