Health History Form

E-mail: Today's Date:

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 questionnaire 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.

Name: (Last First Middle) Home Phone: *Include area code* ( ) Business/Cell Phone: *Include area code* ( )

Address: (Mailing address) City: State: Zip:

Occupation: Height: Weight: Date of birth: Sex: M F

SS# or Patient ID: Emergency Contact: Relationship: Home Phone: ( ) Cell Phone: ( ) *Include area codes*

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

Your Name Relationship

Do you have any of the following diseases or problems: *(Check DK if you Don't Know the answer to the question)*	**Yes**	**No**	**DK**
Active Tuberculosis	☐	☐	☐
Persistent cough greater than a 3 week duration	☐	☐	☐
Cough that produces blood	☐	☐	☐
Been exposed to anyone with tuberculosis	☐	☐	☐

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Dental Information *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?	☐	☐	☐
Are you currently experiencing dental pain or discomfort?	☐	☐	☐
Do you brux or grind your teeth?	☐	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐

What is the reason for your dental visit today?

Name/Address of General Dentist:

Date of your last dental exam:

What was done at that time?

Date of last dental x-rays:

Doctor who referred you to our office:

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problem*

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	☐	☐	☐
Penicillin or other antibiotics	☐	☐	☐
Barbiturates, sedatives, or sleeping pills	☐	☐	☐
Sulfa drugs	☐	☐	☐
Codeine or other narcotics	☐	☐	☐
Are you in good health?	☐	☐	☐
Has there been any change in your general health within the past year?	☐	☐	☐

	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?

	Yes	**No**	**DK**
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 Information

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
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 risedronate (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, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?	☐	☐	☐
Date Treatment began: _____			

	Yes	No	DK
Do you use controlled substances (drugs)?	☐	☐	☐
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 do you typically drink In a week? _____			
WOMEN ONLY Are you:			
Pregnant?	☐	☐	☐
Number of weeks: _____			
Taking birth control pills or hormonal replacement?	☐	☐	☐
Nursing?	☐	☐	☐

Please mark (X) your response to indicate if you have 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	☐	☐	☐
If yes, date:_____			
Heart murmur	☐	☐	☐
Low blood pressure	☐	☐	☐
High blood pressure	☐	☐	☐
Anemia	☐	☐	☐
Other congenital heart defects	☐	☐	☐

	Yes	No	DK
Autoimmune disease	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Systemic lupus erythematosus.	☐	☐	☐
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐
Tuberculosis	☐	☐	☐
Cancer/Chemotherapy/ Radiation Treatment	☐	☐	☐
Chest pain upon exertion	☐	☐	☐
Chronic pain	☐	☐	☐
Diabetes Type I or II	☐	☐	☐
Eating disorder	☐	☐	☐
Malnutrition	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
G.E. Reflux/persistent heartburn	☐	☐	☐
Ulcers	☐	☐	☐
Thyroid problems	☐	☐	☐
Stroke	☐	☐	☐
Glaucoma	☐	☐	☐
Hemophilia	☐	☐	☐
AIDS or HIV infection	☐	☐	☐
Arthritis	☐	☐	☐
Blood transfusion	☐	☐	☐
If yes, date:_____			

	Yes	No	DK
Hepatitis, jaundice or liver disease	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Neurological disorders	☐	☐	☐
If yes, specify:_____			
Sleep disorder	☐	☐	☐
Mental health disorders	☐	☐	☐
Specify:_____			
Recurrent Infections	☐	☐	☐
Type of infection:_____			
Kidney problems	☐	☐	☐
Night sweats	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistent swollen glands in neck	☐	☐	☐
Severe headaches/ migraines	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
Excessive urination	☐	☐	☐
Mitral valve prolapse	☐	☐	☐
Pacemaker	☐	☐	☐
Rheumatic fever	☐	☐	☐
Rheumatic heart disease	☐	☐	☐
Abnormal bleeding	☐	☐	☐

	Yes	No	DK
Has a physician or previous dentist recommended that you take antibiotics prior to your 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: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues 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/her 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:

FOR COMPLETION BY DENTIST

Comments:_____

Date: _____

Please Print *****Only fill this form out if you have dental insurance*****

Primary Dental Insurance

Patient's Name: _____Patients Date of Birth: _____

Insured's Name: _____Relationship_____

Insured's Date of Birth: _____Insured's SS#: _____

Group #: _____ ID #: _____

Insureds Employer: _____

Insurance Company Name: _____Insurance phone# _____

Insurance Company claims Address:_____

_____

Secondary Dental Insurance

Patient's Name: _____Patient's Date of Birth: _____

Insured's Name: _____Relationship _____

Insured's Date of Birth: _____Insured's SS#: _____

Group #: _____ ID #: _____

Insureds Employer: _____

Insurance Company Name: _____Insurance phone# _____

Insurance Company claims Address:_____

_____

Please return with a copy of the front and back of your dental insurance card(s)

Livingston DENTAL PERIODONTICS & IMPLANTS

Informed Consent and Notice of Privacy Practices

SECTION A: PATIENT GIVING CONSENT

PATIENT NAME

ADDRESS

CITY | STATE | ZIP

HOME PHONE | CELL PHONE

EMAIL | PATIENT #

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 heath 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:

LIVINGSTON DENTAL
P: 973.992.1200, F. 973.992.1840
E-mail: livingstondentalperio@gmail.com
531 S. Livingston Ave, Livingston, New Jersey 07039

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 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)

Livingston DENTAL PERIODONTICS & IMPLANTS

OFFICE-PATIENT FINANCIAL POLICY

IN ORDER TO SERVE YOU BETTER, WE ASK THAT ALL THE FINANCIAL INFORMATION BE COMPLETED PRIOR TO SEEING THE DOCTOR.

REGARDING YOUR BILLING AND INSURANCE

PAYMENT IS EXPECTED AT THE TIME OF SERVICE. Payment plans are available. Financing is also available. Please see one of the front desk staff to assist you in the most convenient choice.

Your bill is your responsibility. Your insurance policy is a contract between you and your carrier. WE ARE NOT PARTY TO THAT CONTACT. Pre-authorizations are NOT an absolute agreement by your insurance carrier to pay the amount shown. It is an estimation of benefits (EOB) only. This is CLEARLY stated on the form the insurance carrier sends you.

We will ALWAYS send out your insurance forms within 24 hours. We DO NOT charge ANY additional fee to fill out these forms. If your insurance carrier has the service available, we send the claims ELECTRONICALLY via the Internet within 24 hours of the service billing date. Your signature below will act as your signature on file granting your permission to submit insurance claims electronically on your behalf.

When all insurance claims have been paid, any outstanding balance is YOUR financial responsibility. If your carrier CHOOSES NOT TO PAY please CALL THEM and register your complaints.
We will provide you with a treatment plan for procedures to be done. A copy will be given to you and one will remain in your chart. We ask that you sign this document. This ONLY shows that the plan was presented and is in NO WAY an obligation to do the treatment.

We are ALL committed to providing you with the best treatment that we can. We wish all our arrangements to be as CLEAR as possible. If you should have ANY questions, please do not hesitate to ask at your earliest convenience.

I request that payment of authorized Health Insurance benefits be made to Dr. Brunetti or any of its individual physician members for any services furnished to me by Livingston Dental or any of its individual physician providers. _____Initials

PATIENT ACKNOWLEDGEMENT:

I attest that all information provided to Livingston Dental is accurate. If any information changes, I will inform Livingston Dental _____Initials

I authorize Livingston Dental to release all medical information necessary for processing insurance claims to the insurers on file. I

agree these provisions will be in effect until otherwise revoked by me._____ Initials

Thank you for understanding our OFFICE FINANCIAL POLICY. I have read this document and agree to the OFFICE FINANCIAL POLICY.

SIGNATURE: _____ **DATE:** _____

PATIENT REQUEST FOR TREATMENT

RECEIVING DENTAL TREATMENT DURING THE COVID-19 PANDEMIC AND RE-OPENING OF SERVICES

Dear Patient,

You have come to the office of Livingston Dental: Periodontics & Implant Dentistry LLC for dental care / services that will be performed during the Covid-19 Pandemic and during the reopening phase of businesses. Please be advised of the following:

1. This office complies with CDC, OSHA, ADA, NJDA & NJ-State Board of Dentistry infection control guidelines to limit the spread of the Covid-19 virus. We have implemented many important infection control procedures in our office to supplement our normal infection control procedures to ensure that our patients and staff remain safe. These changes will remain in place as we now gradually reopen; but we cannot make any guarantees.
2. You as the patient acknowledge and understand that there is an increased risk that Covid-19 can be transmitted in any place of public accommodation, including a dental office, and you have been informed that the office of Livingston Dental: Periodontics & Implant Dentistry desires to protect the safety of the patients, staff and other persons who come upon the premises.
3. The office staff and treating dentist are symptom free from the Covid-19 virus to the best of their knowledge and are screened daily upon coming to the office. However, since this office is a place of public accommodation, other persons (including other patients) could be infected with the virus; with or without their knowledge.
4. You as the patient, consent to have vital signs taken & recorded (thermal scan temperature, blood pressure, oxygenation via pulse oximeter) and understand treatment may be cancelled and / or postponed if one or more of your vital signs are outside the accepted range.
5. A pre-appointment and day of appointment questionnaire will be completed as a precondition prior to rendering any treatment. You the patient have confirmed that the answers to both the pre-appointment and day of appointment screening questions are truthful and candid.

I, _____consent to having
(Print your name)
treatment proposed by Anna Brunetti, DMD.

SIGNATURE:_____

DATE: _____

Patient Screening Form

Patient Name: _____

	PRE-APPOINTMENT	IN-OFFICE
	Date:	Date:
Do you/they have fever or have you/they felt hot or feverish recently (14-21 days)?	☐ Yes ☐ No	☐ Yes ☐ No
Are you/they having shortness of breath or other difficulties breathing?	☐ Yes ☐ No	☐ Yes ☐ No
Do you/they have a cough?	☐ Yes ☐ No	☐ Yes ☐ No
Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	☐ Yes ☐ No	☐ Yes ☐ No
Have you/they experienced recent loss of taste or smell?	☐ Yes ☐ No	☐ Yes ☐ No
Are you/they in contact with any confirmed COVID-19 positive patients? *Patients who are well but who have a sick family member at home with COVID-19 should consider postponing elective treatment.*	☐ Yes ☐ No	☐ Yes ☐ No
Is your/their age over 60?	☐ Yes ☐ No	☐ Yes ☐ No
Do you/they have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	☐ Yes ☐ No	☐ Yes ☐ No
Have you/they traveled in the past 14 days?	☐ Yes ☐ No	☐ Yes ☐ No

I attest that my answers above are truthful and valid. I allow Dr. Brunetti to explore any positive responses further, and some positive responses my result in my appointment to be rescheduled.

Patient Signature _____ Date _____ Temperature in office _____

Positive responses to any of these would likely indicate a deeper discussion with the dentist before proceeding with elective dental treatment.

- For testing, see the list of State and Territorial Health Department Websites for your specific area's information.