Wappingers Dental, PLLC

115 New Hackensack Rd.
Wappingers Falls, NY 12590

Date ____ /____ /_____

Health Questionnaire

Name_____ Gender: M F Date of Birth_____ Height_____ Weight_____

Home #_____ Cell #_____ Business #_____

Email Address_____ S.S. #_____

Residence_____

Occupation_____ Employed By: _____

Referred By: _____ Name of Dental Insurance Co._____

Directions:
To answer all questions circle **YES** or **NO** and/or fill in the blank spaces.
Answers to the following questions are for our records only and will be considered confidential.

YES NO . . . . . 1. Are you in good health?
YES NO . . . . . 2. Are you under the care of a physician now? If so, what is the condition being treated? _____
3. What is the name and address of your physician? _____
4. When was your last physical examination? _____
YES NO . . . . . 5. Have you had any serious illness or operation? If so, what was the illness or operation? _____
YES NO . . . . . 6. Have you been hospitalized or had a serious illness within the past five (5) years? If so, what was the problem? _____
YES NO . . . . . 7. Have you been told by your physician that you need to premedicate with antibiotics prior to any dental procedures? If so, which antibiotic is indicated and what dosage? _____
YES NO . . . . . 8. Do you have or have you had any of the following? **(Circle all that apply)**

a. **Rheumatic heart fever**	**i. Rheumatic disease**
b. Heart murmur	**j. Congenital Heart Lesion**
c. Heart Attack	**k. Coronary Insufficiency**
d. Coronary Occlusion	**l. Stroke**
e. Mitral Valve Prolapse	**m. Cardiac Surgery (date :_____)**
f. Pacemaker	**n. Artificial Heart Valves**
g. Angina (Chest pains)	

h. Artificial Joint(s): **Hip** **Knee** **Ankle** **Shoulder**
Date(s) placed _____ _____ _____ _____

YES NO . . . 9. Do you have or have you had an allergic reaction to any of the following: (**Circle all that apply)**

Latex Penicillin Sulfa Drugs Aspirin Food Allergies_____

Codeine Local Anesthetics Hay Fever Dental Materials Food Dies

Gluten Metal Other_____

YES NO . . . 10. Have you undergone current or past osteoporosis therapy? (Ex: Fosamax, Actonel, Boniva) If so, which medication(s) were prescribed? _____
11. Do you or have you had: ***(please list any medications being taken for the indicated disease or condition on the lines provided)***
YES NO . . . . . a. Anemia or Blood Disorder_____
YES NO . . . . . b. Jaundice or Liver Disease_____
YES NO . . . . . c. Diabetes_____
YES NO . . . . . 1. Are you thirsty much of the time?
YES NO . . . . . 2. Are you urinating more than usual?
YES NO . . . . . d. Hiatal Hernia_____

TURN SHEET OVER

YES NO . . . . . e. Acid Reflux or GERD (gastroesophageal reflux) _____
YES NO . . . . . f. Stomach Ulcers_____Crohn's Disease_____
YES NO . . . . . g. Kidney Trouble, transplant, or dialysis_____
YES NO . . . . . h. Inflammatory Rheumatism (painful swollen joints) _____
YES NO . . . . . i. Arthritis_____
YES NO . . . . . j. Asthma_____
YES NO . . . . . k. Tuberculosis_____
YES NO . . . . . 1. Do you have a persistent cough or cough up blood?
YES NO . . . . . l. Hypertension (high blood pressure) _____
YES NO . . . . . m. Hypotension (low blood pressure) _____
YES NO . . . . . n. Thyroid Disease_____
YES NO . . . . . o. Hepatitis (A, B, C or D) _____
YES NO . . . . . p. Sexually Transmitted Disease_____
YES NO . . . . . q. HIV + or AIDS_____
YES NO . . . . . r. Psychiatric Care_____
YES NO . . . . . s. Physical Impairment (hearing, vision, speech, mobility) _____
YES NO . . . . . t. Lupus (SLE) _____
YES NO . . . . . u. Steroid Therapy (e.g. Prednisone) _____
YES NO . . . . . v. Cancer Therapy (Radiation or Chemotherapy) _____
YES NO . . . . . w. Seasonal Allergies_____
YES NO . . . . . x. Other _____
YES NO . . . . . 12. Are you taking any of the following medications? ***(If so please circle and indicate name and dosage of medication being taken)***

a. Antibiotics or Sulfa Drugs_____
b. Anticoagulants (blood thinners)_____
c. Tranquilizers_____
d. Aspirin_____
e. Digitalis or drugs for cardiac conditions_____
f. Nitroglycerin_____
g. Oral Contraceptives_____
h. Vitamins or Supplements_____
i. Other_____

YES NO . . . . . 13. Are you or have you ever been addicted to chemical substances (i.e. alcohol, prescription drugs, heroin, methamphetamine, cocaine, other) _____
YES NO . . . . . 14. Are you or could you be pregnant at this time?
YES NO . . . . . 15. Have you had a history of fainting spells or seizures?

DENTAL HISTORY

YES NO . . . . . 16. Do you have bleeding gums when you brush or floss?
YES NO . . . . . 17. Have you had abnormal bleeding associated with previous dental treatment?

a. Have you ever required a blood transfusion?
b. Have you ever been refused as a blood donor?

YES NO . . . . . 18. Have you noticed any lumps or sores in your mouth?
YES NO . . . . . a. Have you had surgery for a tumor, growth, or condition on the lips or mouth?
YES NO . . . . . 19. Do you wake up with headaches or muscle aches in the face, jaws, or teeth?
YES NO . . . . . a. Have you ever been told you clench or grind your teeth?
YES NO . . . . . 20. Do you get dry mouth often?
YES NO . . . . . 21. Do you have a fear of dentistry? Why? _____
YES NO . . . . . 22. Have you been exposed to increased amounts or x-rays or radiation in the last year? If so why and which body parts? _____
YES NO . . . . . 23. If you have children, do you want to learn how to keep their natural teeth for a lifetime without discomfort?
YES NO . . . . . 24. Is there anything you would like to change about your teeth or smile?

_____

25. Circle all the types of dental treatment you have experienced:

Orthodontics (braces) Root Canal Treatment Implants Dentures Oral Surgery (Extractions)

Periodontal (gum) Treatment TMJ Treatment

I AGREE TO BE TREATED BY WAPPINGERS DENTAL AND I AGREE TO BE FULLY RESPONSIBLE FOR PAYMENT OF TREATMENT**.** ***OUR OFFICE PROCEDURES ARE HIPAA COMPLIANT***

_____ _____

Signature of Patient or Guardian Signature of Doctor

WAPPINGERS DENTAL, PLLC

PATIENT CONFIDENTIALITY

In this office, **Patient Confidentiality** is a prime concern. Please indicate below with whom our office can or cannot leave a message.
Please check where appropriate.

	YES	NO	DOESN'T APPLY
Spouse	_____	_____	_____
Parent	_____	_____	_____
Children	_____	_____	_____
Answering machine			
Home	_____	_____	_____
Work	_____	_____	_____

Are you able to receive calls at your workplace? _____

May we call you at your workplace and state who is calling? _____

Due to our confidentiality regulations, should a family member, friend, or relative contact our office, we are not at liberty to discuss your situation unless we have permission from you, the patient.

Please check with whom we may discuss your situation.

	YES	NO	DOESN'T APPLY
Spouse	_____	_____	_____
Children	_____	_____	_____
Parent	_____	_____	_____

Parent, Children & or Significant Others

Name_____
Relationship_____
Phone_____

Name_____
Relationship_____
Phone_____

_____ _____
Signature Date

Wappingers Dental, PLLC

115 New Hackensack Rd.
Wappingers Falls, NY 12590

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 15, 2013, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies of your x-rays, the charge is $25.00. Copies of other parts of your record will be made at $ 1.00 per page. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as postcards, voicemail messages, or letters).

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 15, 2013. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Office: Wappingers Dental Telephone: 845-297-3950
Address: 115 New Hackensack Rd. Wappingers Falls, NY 12590

HIPAA PRIVACY FORM 2

Acknowledgement of Receipt of Notice of Privacy Practices

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

Wappingers Dental, PLLC.

115 New Hackensack Rd.
Wappingers Falls, NY 12590

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have reviewed 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)

_____

_____

_____