



South Shore Dental Care, P.C.

Dr. Dory Stutman
Dr. Khalida Stutman

4600 SUNRISE HWY • MASSAPEQUA PARK NY 11762

MEDICAL HISTORY

DENTAL INSURANCE

DATE _____

PATIENT NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE _____ BUSINESS PHONE _____

CELL PHONE _____ E-MAIL _____

EMPLOYER _____

S.S.# _____ BIRTH DATE _____

SEX MALE FEMALE MARITAL STATUS _____

SIGNATURE OF THE PERSON RESPONSIBLE FOR PAYMENT OF THIS ACCOUNT. **X** _____

REASON FOR TODAY'S VISIT. _____

DENTAL INSURANCE (PRIMARY) _____

SUBSCRIBER NAME _____

INSUREDS EMPLOYER ADDRESS _____

GROUP # _____

SUBSCRIBER S.S.# _____ D.O.B. _____

INSURED WORK # _____

DENTAL INS. (SECONDARY) _____

SUBSCRIBER S.S.# _____ D.O.B. _____

SUBSCRIBER NAME _____

PHYSICIAN NAME _____

PHYSICIAN NUMBER _____

WHO MAY WE THANK FOR REFERRING YOU ? _____

MEDICAL HISTORY - Certain illnesses and drugs may make it necessary to alter our treatment. In our endeavor to render the best possible oral health care to you, it is necessary to have the following information.

HAVE YOU EVER OR NOW HAVE (Please check yes or no):

- | | | | | | |
|--|---|--|--|---|--|
| Y N | <input type="checkbox"/> <input type="checkbox"/> Allergies to Medicine | Y N | <input type="checkbox"/> <input type="checkbox"/> Diabetes | Y N | <input type="checkbox"/> <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> <input type="checkbox"/> Allergy to Penicillin | <input type="checkbox"/> <input type="checkbox"/> Anemia | <input type="checkbox"/> <input type="checkbox"/> Drug or Alcohol Abuse | <input type="checkbox"/> <input type="checkbox"/> Emotional Disturbance | <input type="checkbox"/> <input type="checkbox"/> Leukemia | <input type="checkbox"/> <input type="checkbox"/> Mental Retardation |
| <input type="checkbox"/> <input type="checkbox"/> Arthritis | <input type="checkbox"/> <input type="checkbox"/> Asthma | <input type="checkbox"/> <input type="checkbox"/> Epilepsy | <input type="checkbox"/> <input type="checkbox"/> Eye Problem | <input type="checkbox"/> <input type="checkbox"/> Oral Ulcers | <input type="checkbox"/> <input type="checkbox"/> Orthopedic Problems |
| <input type="checkbox"/> <input type="checkbox"/> Bladder Conditions | <input type="checkbox"/> <input type="checkbox"/> Blood Pressure Problems | <input type="checkbox"/> <input type="checkbox"/> Excessive Bleeding Problem | <input type="checkbox"/> <input type="checkbox"/> Fainting or Dizziness | <input type="checkbox"/> <input type="checkbox"/> Pacemaker | <input type="checkbox"/> <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> <input type="checkbox"/> Blood Transfusions | <input type="checkbox"/> <input type="checkbox"/> Birth Defects | <input type="checkbox"/> <input type="checkbox"/> Frequent Infections | <input type="checkbox"/> <input type="checkbox"/> Hay Fever | <input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> <input type="checkbox"/> Scoliosis (Curved Spine) |
| <input type="checkbox"/> <input type="checkbox"/> Bone or Joint Problems | <input type="checkbox"/> <input type="checkbox"/> Brain Injury | <input type="checkbox"/> <input type="checkbox"/> Hearing/Speech Problem | <input type="checkbox"/> <input type="checkbox"/> Heart Murmur/Heart Defects | <input type="checkbox"/> <input type="checkbox"/> Sickle Cell Anemia | <input type="checkbox"/> <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> <input type="checkbox"/> Bruising Easily | <input type="checkbox"/> <input type="checkbox"/> Cancer or Malignancies | <input type="checkbox"/> <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> <input type="checkbox"/> Hemophilia | <input type="checkbox"/> <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> <input type="checkbox"/> Chronic Headaches | <input type="checkbox"/> <input type="checkbox"/> Hepatitis or Liver Disease | <input type="checkbox"/> <input type="checkbox"/> HIV Positive | <input type="checkbox"/> <input type="checkbox"/> Ulcers/Stomach Problems | <input type="checkbox"/> <input type="checkbox"/> Veneral Disease/Herpes |
| <input type="checkbox"/> <input type="checkbox"/> Cleft Lip/Palate | <input type="checkbox"/> <input type="checkbox"/> Convulsions/Seizures | <input type="checkbox"/> <input type="checkbox"/> Implants | <input type="checkbox"/> <input type="checkbox"/> Jaundice | <input type="checkbox"/> <input type="checkbox"/> Other _____ | |

Do wounds heal slowly or present complications? Yes No

Presently taking medication? (Please Specify) _____

Presently under a physician's care? Yes No

When was your last physical exam? _____

Have you ever been hospitalized? Date (s) _____ Reason (s) _____

Have you ever had x-ray treatment or chemotherapy? Yes No

Please describe any current medical treatment including drugs, pending surgery, recent injuries or any other information I should be aware of that has not been covered: _____

DENTAL HIPAA NOTICE

WE ARE REQUIRED BY LAW TO:

MAINTAIN THE PRIVACY OF YOUR PERSONAL HEALTH INFORMATION, PROVIDE YOU THIS NOTICE OF OUR LEGAL DUTIES AND PRIVACY PRACTICES WITH RESPECT TO YOUR PERSONAL HEALTH INFORMATION, AND, FOLLOW THE TERMS OF THIS NOTICE.

PLEASE LIST INDIVIDUALS WHO HAVE YOUR CONSENT TO RECEIVE INFORMATION ON YOUR BEHALF.

WE WILL RESPECT YOUR PERSONAL HEALTH INFORMATION FROM INAPPROPRIATE USE OR DISCLOSURE.

Signed _____ **Date** _____

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