HEALTH HISTORY
(PLEASE COMPLETE IN BLUE OR BLACK INK)

Patient's Name: ______________________ How do you prefer to be addressed? ______________

Answers to the following questions are for our records only and will be considered confidential. **Circle One**

1. Date of Last Physical Examination ___/___/___ Physician's Name ______________
2. Date of Last Dental Examination ___/___/___ Dentist's Name ______________
3. Date of Last Dental X-Rays ___/___/___
4. Are you having pain or discomfort at this time? ______________ **YES** **NO**
5. Do you feel very nervous about having dental treatment? ______________ **YES** **NO**
6. Have you ever had a bad experience in the dental office? ______________ **YES** **NO**
7. Is there anything that you dislike about your smile? ______________ **YES** **NO**
8. Have you been a patient in the hospital during the past two years? What for? ______________ **YES** **NO**
9. Have you been under the care of a medical doctor during the past two years? What for? ______________ **YES** **NO**
10. List any medicines /drugs taken in the past two years and what for? ______________
11. List all current medicines and what for? ______________

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12. Are you allergic to (i.e., itching, rash, swelling of hands, feet or eyes, or made sick) penicillin, aspirin, codeine, any drugs, medications, metals, or latex? ______________ **YES** **NO**

    If yes, please list: ______________
13. Have you ever had any excessive bleeding requiring special treatment? ______________ **YES** **NO**
14. Circle any of the following which you have had or have at present:

Heart Failure	Psychiatric Treatment	Glaucoma	Fainting or Dizzy Spells
Heart Disease or Attack	Emphysema	Pain in Jaw Joints	★ Any type of Implant (Heart Valve, etc.)
Angina Pectoris	Cough	Birth Defects	Sickle Cell Disease
High Blood Pressure	Tuberculosis (TB)	HIV Positive, ARC, AIDS	Bruise Easily
★ Heart Murmur	Asthma	Hepatitis A (infectious)	★ Artificial Hip, Knee or other joint
Rheumatic Fever	Hay Fever	Hepatitis B (serum)	MRSA
★ Congenital Heart Lesions	Sinus Trouble	Hepatitis C	
Use of Tobacco Products	Allergies or Hives	Liver Disease	
Thyroid Disease	Diabetes	Jaundice	
Heart Pacemaker	Sexually Transmitted Diseases	Blood Transfusion	
Heart Surgery	Radiation Therapy	Drug Addiction	
Cancer (Type________)	Chemotherapy (Cancer, Leukemia)	Hemophilia	
Anemia	Arthritis	★ Any type of transplant	ARE YOU PRESENTLY
Stroke	Alcoholism	Cold Sores	TAKING A BLOOD
Kidney Trouble	Rheumatism	Herpes	THINNER? YES NO
Ulcers	Cortisone Medicine	Epilepsy or Seizures	

★Antibiotic premedication may be required prior to your appointment.

15. Are you taking any herbal medications? ______________ **YES** **NO**
16. Are there any growths or sores in or around your mouth? ______________ **YES** **NO**
17. Do you have any trouble chewing? ______________ **YES** **NO**
18. Does food catch between your teeth? ______________ **YES** **NO**
19. Do you have pain in or near your ears? ______________ **YES** **NO**
20. Do you habitually clench or grind your teeth during the day or night? ______________ **YES** **NO**
21. Have you ever been told that you have gum problems? ______________ **YES** **NO**
22. Do you now have bleeding gums or any other gum condition? ______________ **YES** **NO**
23. Do you have a family history of Gum Disease? ______________ **YES** **NO**
24. **WOMEN:** Are you pregnant now? ______________ **YES** **NO**
25. Is there anything related to your medical or dental history that you have not indicated above? ______________ **YES** **NO**

    If yes, explain: ______________

I hereby authorize Dr. Dina L. Nuhfer and staff to perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page is correct to the best of my knowledge. I authorize release of any information relating to treatment. I understand that I am responsible for all costs of dental treatment.

SIGNATURE: ______________________ **Date:** ____________

PATIENT INFORMATION

Name: ______________________ Home Phone: ( ) ______

Address: ______________________ Work Phone: ( ) ______

______________________ Cell Phone: ( ) ______

City: __________ State: ______ Zip: ______ Employer: ______

Social Security #: __________ Birth Date: / / Age: ______

Sex: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

E-mail Address: ______________________

Would you like us to confirm your appointments by e-mail? ☐ YES ☐ NO

Family Physician: Physician's Phone:

Who can we thank for referring you? Please Check One. ☐ Patient: ______________

☐ North East News Journal ☐ Facebook ☐ Google Reviews ☐ Postcard ☐ Other:______________

GUARANTOR / FINANCIALLY RESPONSIBLE PARTY INFORMATION

Name: ______________________ Home Phone: ( ) ______

Address: ______________________ Work Phone: ( ) ______

______________________ Cell Phone: ( ) ______

City: __________ State: ______ Zip: ______ Employer: ______

Guarantor's S.S. #: __________ Guarantor's Birth Date: / /

PRIMARY DENTAL INSURANCE

Insurance Co.: ______

Name of Insured: ______

Insured's Date of Birth: ______

Insurance Address: ______

City: ______ State: ______ Zip: ______

Insurance Phone: ( ) ______

Policy/ID #: ______

Group #: ______

Employer Paid Plan? ☐ Yes ☐ No

Relationship of Patient to Insured:

☐ Self ☐ Spouse ☐ Child ☐ Other

SECONDARY DENTAL INSURANCE

Insurance Co.: ______

Name of Insured: ______

Insured's Date of Birth: ______

Insurance Address: ______

City: ______ State: ______ Zip: ______

Insurance Phone: ( ) ______

Policy/ID #: ______

Group #: ______

Employer Paid Plan? ☐ Yes ☐ No

Relationship of Patient to Insured:

☐ Self ☐ Spouse ☐ Child ☐ Other

To the best of my knowledge, the questions on this form have been accurately answered. I authorize the dentist to release any information including the diagnosis and the records of any treatment and examination rendered to my dependents or me during the period of such dental care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

______________________ ______________

Signature of Patient or Parent if minor Date

North East Dental Arts

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: ____

Address: ____

Telephone: ____________________ Social Security #: ____________________

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 o 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 Practice, 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: Administrative Office
Address: 90 East Main Street, North East, PA 16428
Telephone: (814) 725-4700 **Fax:** (814) 725-3953

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 receive 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 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 THIS CONSENT AFTER YOU SIGN IT. **SEE OTHER SIDE →**

North East Dental Arts

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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

I, ________________________________ have received 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) _______________________________________

Comments: ____

____

____

____

____

NORTH EAST Dental Arts EST. 1998

CANCELLATION / BROKEN APPOINTMENT POLICY

- We ask our patients to ***PLEASE provide at least 48 hours' notice*** if they cannot keep an appointment.

- **Your courtesy** of providing adequate notice, frees up valuable schedule time for those patients who are on a wait-list or are in need of emergency services.

- The practice reserves the right to assess a reasonable fee to those patients who do not honor their reserved visit or who do not provide adequate cancellation notice.

Policy and Fees:

- There is NO CHARGE for cancelling/rescheduling with 48-hours notice.

- SAME DAY CANCELLATIONS – fees are applied at our discretion.

- NO SHOW --- fees are applied to the patient's account as follows.

  - **$40** for a broken hygiene appointment

  - **$75** for a broken doctor's appointment scheduled for one hour or less, each additional hour incurs an additional fee of **$50**

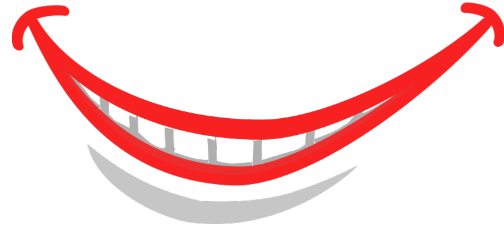
I have read and understand the above mentioned policy.

____ ________________________

Patient's Signature (Parent/Guardian if minor) ***Today's Date***

90 East Main Street North East, PA 16428
Phone – 814-725-4700 www.NorthEastDentalArts.com

NORTH EAST
Dental Arts
EST. 1998



Smile Analysis

Please circle Yes or No

Yes No Are your lower six front teeth straight?

Yes No Do you have any gaps or spaces between your teeth?

Yes No Are any of your teeth turned, crooked or uneven?

Yes No When you bite your front teeth (biting a sandwich) do all the front teeth come in contact?

Yes No Are the Upper front teeth straight? (versus being crooked, overlapped, Or protruding)

Yes No When you bite down with your back teeth (when you swallow), do all the Front teeth come in contact?

Yes No Do you usually smile with your mouth closed for pictures?

Yes No Do you want to change anything about your teeth?

Yes No Would you like to change anything about the appearance of your smile or teeth.

Yes No Would you like whiter teeth.

On a scale of 1-10, how would you rate your smile (10 being a Hollywood smile)? ________

NORTH EAST Dental Arts EST. 1998

COMFORT MENU

We want to make your dental visit as comfortable as possible.

Our practice has created a welcoming, relaxing environment. Our beautiful office includes a refreshment center with coffee, tea and water. A staff member will see to your every need. Our entire team has received special training in providing exquisite, comfortable dental care. You will be amazed with our 5-star service……absolutely!

In order to assure a comfortable and relaxing appointment for you, we have the following items available upon request at no charge:

THROW BLANKET	NECK CUSHION
HEAD PILLOW	LEG PILLOW
LIP BALM	SUNGLASSES
TYLENOL	ADVIL
COFFEE	HOT TEA
BOTTLED WATER	HOT CHOCOLATE

WIRELESS INTERNET

ACCESS CODE: flossdaily