Central Jersey Periodontics & Implants

Acknowledgement of receipt of notice of privacy practices

You may refuse to sign this acknowledgement*

As required by the HIPAA act, this acknowledges that we have displayed a copy of this office's Notice of Privacy Practices for your viewing. (Copy of Notice of Privacy Practices is available for you upon request.)

(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
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknolwedgement
- ☐ Other (please specify)

Medical Information	YES	NO	DK*
1. Do you consider yourself to be in good health?			
2. Are you presently under a physician's care?			
3. Are you taking any medicine at this time? Please list.			
4. Have you had any major operations?			
5. Have you been seriously ill or hospitalized?			
6. Do you have any pain or discomfort?			
7. Have you ever had any abnormal bleeding?			
8. Have you ever been told to pre medicate before dental visits?			
9. Have you ever been treated for osteoporosis?			
10. Do you have any artificial hips, joints, rods, pins, etc?			
11. Do you have any history of heart trouble or heart murmur?			
12. Have you ever had rheumatic heart disease/rheumatic fever?			
13. Any history of infectious diseases?			
14. Ever been told you have high blood pressure?			
15. Do you or a blood relative have diabetes?			
16. Have you ever been treated for glandular disorders?			
17. Are you allergic or sensitive to any medicine? Aspirin Advil Penicillin Codeine Tetracycline Erythromycin Clindamycin Percodan Amoxicillin	circle all that apply		
18. Have you ever had cortisone?			
19. Are you on a special diet?			
20. Have you ever had an ulcer or stomach trouble?			
21. Have you ever had kdiney or bladder trouble?			
22. Have you ever had severe pains in the face or head?			
23. Are you under any unusual or abnormal tension?			
24. Do you consider yourself a tense person?			
25. Do you experience extensive anxiety at the dentist?			
26. Do you bruise easily?			
27. Do you get frequent headaches, jaw aches, or earaches?			

*DK = Don't Know

Central Jersey Periodontics & Implants

Please Print *Date*

Dr, Mr, Mrs, Ms. *E-mail* *Referred by*

Date of birth *SS#* *Home phone #* *Cell #*

Address *City* *State* *Zip*

Occupation *Employer* *Phone #*

Spouse's name *Employer* *Date of birth* *SS#*

Dentist's name *Phone #* *Address*

Physician's name *Phone #* *Address*

Main problem/concern

Primary dental insurance

Subscriber *DOB* *Employer*

Insurance company *ID#*

Insurance address *Phone #*

City *State* *Zip* *Group #*

Secondary dental insurance

Subscriber *DOB* *Employer*

Insurance company *ID#*

Insurance address *Phone #*

City *State* *Zip* *Group #*

Authorization to release information

I hereby authorize this office to provide on my behalf any insurance company, claim administrator and consulting health care professional, information concerning health care, advice or supplies provided. This information will be used only for the purpose of evaluating and administering claims for benefits.

Patient or authorized guardian's signature *Date*