Framingham Dental Group, P.C.
Patient History Form

"Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help you meet all your dental healthcare goals, please fill out these forms completely and sign and date the back of the last page. If you have any questions or need assistance, please ask, we will be happy to help."

Patient Information

Date _____

Name_____**D.O.B.**_____
Address_____**City/State**_____**Zip**_____
Home Tel: _____**Work:** _____**Cell:**_____
Email_____

Person to contact in case of emergency_____ **Tel:** _____
Whom may we thank for referring you? _____

Responsible Party

Name of person responsible for this account _____**Relationship to patient**_____
Address if different from above _____**City/State** _____ **Zip** _____
Email _____**D.O.B.** _____**Home Tel:** _____
Employer _____**Work Tel:** _____
Is this person currently a patient in this office? _____**Cell:** _____

Insurance Information

Name of insured _____ **Relationship to patient** _____
D.O.B. _____**Insurance ID#** _____**Group #** _____
Employer _____**Insurance Company** _____**Effective Date** _____
Insurance Co. Address _____
City/State _____ **Zip**_____ **Telephone** _____

Do you have a secondary dental insurance carrier?

Name of insured_____ **Relationship to patient** _____
D.O.B. _____**Insurance ID#** _____**Group #** _____
Employer _____**Insurance Company** _____**Effective Date** _____
Insurance Co. Address _____
City/State _____ **Zip**_____ **Telephone** _____

HEALTH HISTORY

Patient Name: _____ **D.O.B.** _____ **Today's Date:** _____
Address: _____
Telephone: _____ **E-mail:** _____

Please list the names and phone numbers of physicians providing your care:

1. _____
2. _____
3. _____

Date of last healthcare exam: _____ **What was exam for?** _____

Have you been hospitalized in the past 5 years? ***No*** ***Yes***
If yes, reason: _____

Please circle *yes* or *no* for the following conditions:

Anemia or Blood Disorder	No	Yes	Hepatitis, type_____	No	Yes
Arthritis, Rheumatism, or any Inflammatory disease	No	Yes	Joint Replacement Date placed? _____	No	Yes
Asthma	No	Yes	Kidney Disease	No	Yes
Abnormal bleeding from cut	No	Yes	Liver Disease/Jaundice	No	Yes
Cancer or Tumor, type_____	No	Yes	Sore/enlarged lymph nodes	No	Yes
Diabetes	No	Yes	Psychosis	No	Yes
Emphysema or other Respiratory/ Lung Illnesses	No	Yes	Previous Biopsies, type_____	No	Yes
			Radiation or Chemotherapy	No	Yes
Fainting/Dizzy spells	No	Yes	Rheumatic Fever	No	Yes
Glaucoma	No	Yes	Slow-healing mouth sores	No	Yes
Abnormal heart or previous Bacterial Endocarditis	No	Yes	Unintentional weight loss/gain	No	Yes
			H.I.V. Infection/AIDS or ARC	No	Yes
Heart Valve (artificial)	No	Yes	Venereal Disease	No	Yes
Heart or Organ Transplant	No	Yes	Other Conditions/please explain:	No	Yes
Heart Stent Date placed? _____	No	Yes	_____		

Are you taking any of these medications?

Antibiotics before dental treatment?	No	Yes	Antacids	No	Yes
Tagamet (cimetidine) or Prilosec (omeprazole)?	No	Yes	Dilantin/Tegretol	No	Yes
Cardizem (diltiazem) or Calan, Isoptin (verapamil)	No	Yes	Serzone (nefazodone)	No	Yes
Dilantin or Tegretol	No	Yes	Diflucan (fluconazole) or	No	Yes
Barbiturates (any)	No	Yes	Sporonox (itraconazole)		
St. John's Wort/Kava-Kava	No	Yes	Biaxin (clarithromycin)	No	Yes

Have you ever been treated with Bisphosphonate drugs (fosomax, Aredia, Zometa, Actonel, Bonive) **No** **Yes**
If yes, when did the treatment begin? _____ **when did treatment end?** _____
Have you ever taken prescription drugs such as fen-phen for weight loss? **No** **Yes**
Do you consume grapefruit juice, grapefruits or grapefruit extract? **No** **Yes**

Please list any prescriptions you are currently taking and dosages:

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

-- OVER --

Please list any over the counter vitamins or minerals you are taking, and for what purpose:

1. _____ **2.** _____
3. _____ **4.** _____
5. _____ **6.** _____

Women: Are you pregnant?	**No**	**Yes**
If no, are you planning a pregnancy in the near future?	**No**	**Yes**
Are you a nursing mother?	**No**	**Yes**
Are you taking birth control pills?	**No**	**Yes**
Abnormal Blood Pressure?	**No**	**Yes**
Have you ever received a diagnosis of *High Blood Pressure*?	**No**	**Yes**

What is your normal blood pressure? S /D Today: _____

Are you allergic or have you had any reaction to:

a. Local anesthetics	**No**	**Yes**
b. Penicillin or other antibiotics	**No**	**Yes**
c. Aspirin, Ibuprofen or Tylenol	**No**	**Yes**
d. Codeine, Valium or other sedatives	**No**	**Yes**
e. Latex or Metals	**No**	**Yes**
f. Any Other Allergies (please specify)	**No**	**Yes**

Tobacco, Alcohol, Drugs:

Do you use tobacco? Circle: NO YES type: smoke chew How much per day? For how long?
Do you want to quit using tobacco No Yes
Do you consume alcohol? If yes, approximately how much alcoholic beverage per week? _____
Do you use any mood altering drugs other than those previously listed? _____

Weight: Meals per Day: Dietary Restrictions: Food Allergies:

Sugar in your diet (circle one): none slight moderate high

****

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health and medication.

Patient (print name)	**Patient or Guardian Signature**	**Date**
Doctor (print name)	**Doctor Signature**	**Date**

I have reviewed the attached Health History. My health and meds have changed as follows or write "no change"

Date: Changes: Doctors Signature: Patient/Guardian

_____

_____

Previous Dental office: _____

_____

_____

AUTHORIZATION FOR RELEASE OF RADIOGRAPHS

Date: _____

Name: _____

Address: _____

_____

I hereby request transfer of x-rays for:

_____ Myself

_____ My Child/Children

Name(s) _____

_____ A Patient for whom I am legal guardian

Name _____

Please transfer to the following dental office:

Framingham Dental Group
Dr. Richard S. Tutin
1671 Worcester Road, Suite 103
Framingham, MA 01701
Phone (508) 872-0041
E-Mail: framinghamdentalgroup@gmail.com

Patient Signature: _____

FRAMINGHAM DENTAL GROUP **1671 Worcester Road Framingham, MA 01701**

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 read this notice carefully. The privacy of your health information is important to us.

OUR LEGAL DUTY

Federal and state law mandates that we maintain the privacy of your health information. That law requires us to provide this notice of our privacy practices, legal duties, and your rights with regard to this information. We must follow the practices described in this notice while it is in effect. This notice takes effect 4/14/2003 and remains in effect until we replace it.

We reserve the right to change our privacy practices as permitted by applicable law and the new terms of our notice effective for information maintained by us, including that which was created or maintained prior to the change. Before we make a significant change in privacy practices, we will change this notice and make the new notice available upon request.

You are entitled to a copy of our notice at any time. For more information on our privacy practices, please contact us using the information listed at the end of this notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

Examples of how we may use and disclose health information about you for treatment, payment and healthcare operations:

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 provided to you.

HEALTHCARE OPERATIONS: We may use and disclose your health information in connection with our healthcare operations, including quality assessment, improvement activities, review of competence or qualification of healthcare professionals, conducting training, certification, licensing or credentialing activity.

YOUR AUTHORIZATION: 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 uses or disclosures permitted by the authorization while it was in effect. Unless you give us a written authorization, we can't 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, but may also disclose your health information to a friend, family member 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. We will also use our best professional judgment and experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up healthcare products (prescription included), medical supplies, x-rays or other similar forms of health information.

DISASTER RELIEF: We may disclose your health information to a public or private entity authorized by law or its charter to assist in disaster relief efforts.

PUBLIC BENEFIT: We may use or disclose your health information as authorized by law for purposes deemed to be in the public interest or benefit such as:

Those purposes required by law

Public health activity, disease/vital statistic reporting, child abuse reporting, FDA oversight, to employers regarding work-related injury/illness

Reporting adult abuse, neglect or domestic violence

In response to court and administrative orders, subpoenas, and other lawful process

To coroners, medical examiners, and funeral directors

To organ procurement organizations

To military and federal officials for lawful intelligence, counterintelligence and national security activities

To correctional institutions regarding inmates

As authorized by state worker compensation law

APPOINTMENT: We may use or disclose your health information to provide you with appointments and/or appointment reminders such as voice mail messages, postcards or letters.

PATIENT RIGHTS

ACCESS: You have the right to view or get copies of your health information, with limited exception. You must make a request in writing to obtain access to your health information. You may obtain a form to request the information by using the contact information at the end of this notice. We will charge a cost-based fee for providing this health information.

DISCLOSURE ACCOUNTING: You have the right to request a list of instances in which we or our business associates disclosed your health information over the last six years (but not prior to 4/14/03). That list will not include disclosures for treatment, payment, healthcare operations, as authorized by you, and for certain other activities. If requested more than once in a 12-month period, there will be a cost-based fee for responding to additional requests.

RESTRICTION: You have the right to request (in writing) 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). Your request is not binding unless our agreement is in writing.

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 this request in writing and specify the alternative means or location, along with explanation of how you will handle payment 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 explain why we should amend the information. We may deny the request under certain circumstances.

QUESTIONS AND COMPLAINTS

If you require 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

Made a decision about access to your health information incorrectly

Incorrectly responded to a request you made to amend or restrict the use of your health information

Failed to communicate with you by alternative means or at alternative locations

you may contact us using the information below. You also may submit a written complaint to the US Dept. of Health & Human Services. We will provide you with the address to file this complaint 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 either with us or with the US Dept. of Health and Human Services.

CONTACT INFORMATION

Contact Officer: Deborah Lukey
Telephone (508) 879-6606, (508) 872-0041 Fax:(508)879-7482
Address: 1671 Worcester Road Framingham, MA 01701

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE

Framingham Dental Group

Section A – Patient

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Section B – Privacy Practices Notice Acknowledgement

I, (printed name) _____, acknowledge that I have been given a Notice of Privacy Practices from the above named office.

* Signature: _____Date: _____

For a personal representative signing on behalf of the individual:

Personal Representative Name: _____

Personal Representative Signature: _____

Relationship to Individual: _____

Date: _____

Section C – Good Faith Effort to Obtain Acknowledgement

Description of good faith effort to obtain the individual's signature: _____

_____

_____

Description of why signature could not be obtained: _____

_____

_____

Signature

I verify that the above information is correct.

* Signature: _____ Date: _____