GILMAN ORTHODONTIC ASSOCIATES, P.C.

Medical Health History

Patient's Name ____________________

THANK YOU for taking the time to provide us with this essential information. It will be used each time we select the safest and most effective means of providing you with dental care. Of course, all information on this form is completely confidential.

1. Please describe your present health: .... Excellent ☐ Good ☐ Fair ☐ Poor ☐
2. Has your present health CHANGED in the last year? .... Yes ☐ No ☐
3. Have you ever been HOSPITALIZED for illness or surgery? .... Yes ☐ No ☐
4. Has a doctor treated you for any condition in the last two years .... Yes ☐ No ☐
5. Are you ALLERGIC to any drugs or other substances, including LATEX? .... Yes ☐ No ☐
6. Have you ever experienced BLEEDING that was difficult to stop? .... Yes ☐ No ☐
7. Has anyone in your family ever had DIABETES? .... Yes ☐ No ☐
8. Are you required to restrict your work or ACTIVITY? .... Yes ☐ No ☐
9. Is your DIET restricted or specially prescribed? .... Yes ☐ No ☐
10. Are you taking any MEDICATIONS (even aspirin, vitamins, hormones, or antacids)? .... Yes ☐ No ☐
    If so, please list them with dosages:
11. **Do you require antibiotic premedication prior to dental procedures?** .... Yes ☐ No ☐

Physicians name, address & phone number ____________________

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PLEASE INDICATE YES OR NO FOR ANY CONDITION EVEN IF YOU NO LONGER HAVE IT.

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
Heart Trouble	Yes ☐	No ☐	Hepatitis	Yes ☐	No ☐	Emotional Problems or Tension	Yes ☐	No ☐
Heart Murmur	Yes ☐	No ☐	Jaundice	Yes ☐	No ☐	Often Thirsty	Yes ☐	No ☐
Heart Surgery	Yes ☐	No ☐	Diabetes	Yes ☐	No ☐	Frequent Urination	Yes ☐	No ☐
Rheumatic Fever	Yes ☐	No ☐	Kidney Disease	Yes ☐	No ☐	Often Fatigued or Exhausted	Yes ☐	No ☐
Congenital Heart Lesions/Defects	Yes ☐	No ☐	Liver Disease	Yes ☐	No ☐	Frequent Headaches	Yes ☐	No ☐
Heart Pacemaker	Yes ☐	No ☐	Persistent Cough	Yes ☐	No ☐	Heavy Smoker	Yes ☐	No ☐
Heart Valve Prosthesis	Yes ☐	No ☐	Asthma	Yes ☐	No ☐	Nervous/Anxious	Yes ☐	No ☐
Heart Attack	Yes ☐	No ☐	Lung Disease	Yes ☐	No ☐	Depressed/Unhappy	Yes ☐	No ☐
High Blood Pressure	Yes ☐	No ☐	Tuberculosis	Yes ☐	No ☐	Any recent unintentional Weight Changes	Yes ☐	No ☐
Low Blood Pressure	Yes ☐	No ☐	Bronchitis	Yes ☐	No ☐	Sinus Trouble	Yes ☐	No ☐
Ankles Swell	Yes ☐	No ☐	Frequent Colds/ Sore Throats	Yes ☐	No ☐	Artificial Joints	Yes ☐	No ☐
Hardening of Arteries	Yes ☐	No ☐	Emphysema	Yes ☐	No ☐	Swollen Lymph Glands	Yes ☐	No ☐
Shortness of Breath on Mild Exertion	Yes ☐	No ☐	Epilepsy	Yes ☐	No ☐	Immune System Problems	Yes ☐	No ☐
Chest pains on Mild Exertion	Yes ☐	No ☐	Fainting	Yes ☐	No ☐	Psychiatric Care	Yes ☐	No ☐
Scarlet Fever	Yes ☐	No ☐	Ulcers	Yes ☐	No ☐	Venereal Disease	Yes ☐	No ☐
Hives/Rash	Yes ☐	No ☐	Stroke	Yes ☐	No ☐	Thyroid/Parathyroid Disorders	Yes ☐	No ☐
Hay Fever	Yes ☐	No ☐	Arthritis	Yes ☐	No ☐	Cancer Treatment	Yes ☐	No ☐
Recurrent Illness	Yes ☐	No ☐	Anemia/Blood Disease	Yes ☐	No ☐			
			Glaucoma	Yes ☐	No ☐			
			Tumors/Growths	Yes ☐	No ☐			
			Infections	Yes ☐	No ☐			

IF FEMALE, ARE YOU:

Pregnant	Yes ☐	No ☐	On Birth Control Pills	Yes ☐	No ☐	In or Past Menopause	Yes ☐	No ☐

IS THERE ANY CONDITION OR PROBLEM THAT YOU THINK WE SHOULD KNOW ABOUT?

____

COMMENTS: ____________________

____________________ DATE: ____________________

Patient's Signature
(Or Parent or Guardian if Patient is a Minor)

REVIEWED BY: ____________________

PLEASE TURN OVER - PLEASE SIGN BOTH SIDES

Dental History

To assist us in understanding your dental condition and experiences, would you please answer the following questions. If you have any doubts about the information requested please ask the doctor.

HAVE YOU EVER HAD THE FOLLOWING TREATMENT:

1. Orthodontic (straightening of your teeth)........ Yes ☐ No ☐
As a child ☐, or adult ☐. Happy ☐, or unhappy ☐ with result.

2. Extractions........ Yes ☐ No ☐
How long ago__________ Reason for extraction

3. Periodontal treatment (gum treatment)........ Yes ☐ No ☐
How long ago__________________ Describe treatment __________________

4. Mouthguard or splint (plastic device between your teeth)........ Yes ☐ No ☐

5. Treatment or surgery to change your bite........ Yes ☐ No ☐

ARE YOU AWARE OF ANY OF THE FOLLOWING CONDITIONS:

6. Sores, lumps or irritated areas in your mouth........ Yes ☐ No ☐

7. Food catching or collecting between your teeth........ Yes ☐ No ☐

8. Clenching or grinding your teeth........ Yes ☐ No ☐

9. Clicking, popping or grating noise in your jaw when chewing........ Yes ☐ No ☐
Does it bother you

10. Numbness or tingling in your mouth or face........ Yes ☐ No ☐

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11. Over the past five years how often have you been seen for teeth cleanings__________________ .....

12. The date of your last visit to a dentist______________________. That dentist's name ______________________

13. If you wear dentures, do they fit well........ Yes ☐ No ☐
How old are they__________________. Are There any sore areas Yes ☐ No ☐

14. Are you frightened or anxious about dental treatment........ Yes ☐ No ☐

15. Have you had an unpleasant experience at a dental office........ Yes ☐ No ☐
Would you be willing to tell us about it so we avoid a similar experience........ Yes ☐ No ☐

16. Would you change anything about your teeth or smile........ Yes ☐ No ☐

17. What one aspect of dental treatment/care are you most concerned with.
Quality ☐ Cost ☐ Discomfort ☐ Time ☐

Date: ______________________ **Patient's Signature:** ______________________
(Or Parent or Guardian if Patient is a Minor)

PLEASE TURN OVER - PLEASE SIGN BOTH SIDES

Gilman Orthodontic Associates, P.C.
525 Townline Road
Hauppauge, N.Y. 11788

PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is issued. "HIPAA" provides penalties for covered entities that misuse personal health information. As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Your protected health information (ie: individually identifiable information such as names, dates, phone/fax numbers, e-mail addresses, home addresses, social security numbers, and demographic data) may be used or disclosed by us in one or more of the following respects:

- To other health care providers (ie: your general dentist, oral surgeon, etc.) in connection with our rendering orthodontic treatment to you (ie: to determine the results of cleanings, surgery, etc.);
- To third party payers or spouses (ie: insurance companies, employers with direct reimbursement, administrators of flexible spending accounts, etc.) in order to obtain payment of your account (ie: to determine benefits, dates of payment, etc.);
- To certifying, licensing and accrediting bodies (ie: the American Board of Orthodontics, state dental boards, etc.) in connection with obtaining certification, licensure, or accreditation;
- Internally, to all staff members who have any role in your treatment;
- To other patients and third parties who may see or overhear incidental disclosures about your treatment, scheduling, etc.;
- To your family and close friends involved in your treatment; and/or,
- We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses or disclosures of your protected health information will be made only after obtaining your written authorization, which you have the right to revoke.

Under the new privacy rules, you have the right to:

- Request restrictions on the use and disclosure of your protected health information;
- Request confidential communication of your protected health information;
- Inspect and obtain copies of your protected health information through asking us;
- Amend or modify your protected health information in certain circumstances;
- Receive an accounting of certain disclosures made by us of your protected health information, and,
- You may, without risk of retaliation, file a complaint as to any violation by us of your privacy rights with us (by submitting inquiries to our Privacy Contact Person at our office address) or the Unites States Secretary of Health and Human Services (which must be filed within 180 days of the violation).

(Please turn over and sign)

We have the following duties under the privacy rules:

- By law, to maintain the privacy of protected health information and to provide you with this notice setting forth our legal duties and privacy practices with respect to such information;
- To abide by the terms of our Privacy Notice that is currently in effect;
- To advise you of our right to change the terms of this Privacy Notice and to make the new notice provisions effective for all protected health information maintained by us, and that if we do so, we will provide you with a copy of the revised Privacy Notice.

Please note that we are not obligated to:

- Honor any request by you to restrict the use or disclosure of your protected health information;
- Amend your protected health information if, for example, if it is accurate and complete;
  or
- Provide an atmosphere that is totally free of the possibility that your protected health information may be incidentally overheard by other patients and third parties.

This privacy notice is effective as of the date of your signature. If you have any questions about the information in this Notice, please ask us for our Privacy Contact Person or direct your questions to this person at our office address. ***Thank you.***

PATIENT ACKNOWLEDGEMENT

I hereby acknowledge that I have received and reviewed a copy of the Privacy Notice.

________________________________ ____________________

PATIENT'S NAME (Please Print) Date

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PATIENT'S SIGNATURE (or a Parent or Guardian if patient is a minor)