MEDICAL AND DENTAL HEALTH HISTORY NAME________________________BIRTHDATE____/____/_____TODAY'S DATE_____/___/_____

Do you have or have you had any of the following?
(Please check any that apply)

- ❑ Cancer or tumor
- ❑ Heart ailment or angina
- ❑ Heart murmur, mitral valve prolapse, heart defect
- ❑ Rheumatic fever or rheumatic heart disease
- ❑ Artificial joint or valve
- ❑ High or low blood pressure
- ❑ Pacemaker and/or Defibrillator
- ❑ Tuberculosis or other lung problems
- ❑ Kidney disease
- ❑ Hepatitis or other liver disease
- ❑ Alcoholism
- ❑ Blood transfusion
- ❑ Diabetes
- ❑ Neurologic condition
- ❑ Epilepsy, seizures, or fainting spells
- ❑ Emotional condition
- ❑ Arthritis
- ❑ Herpes or cold sores
- ❑ AIDS or HIV positive
- ❑ Migraine headaches or frequent headaches
- ❑ Anemia or blood disorders
- ❑ Abnormal bleeding after extractions, surgery, or trauma
- ❑ Hayfever or sinus trouble
- ❑ Allergies or hives
- ❑ Asthma

Are you allergic to, or have you reacted adversely to any of the following?

- ❑ Latex materials
- ❑ Bananas
- ❑ Penicillin or other antibiotics
- ❑ Local anesthetics ("Novocaine")
- ❑ Codeine or other narcotics
- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Aspirin
- ❑ Other:_______________________________________

Women:

- ❑ May be pregnant
  Expected delivery date: ______________
- ❑ Taking hormones or contraceptives

Are you taking any of the following?

- ❑ Aspirin
- ❑ Anticoagulants (blood thinners)
- ❑ Antibiotics or sulfa drugs
- ❑ High blood pressure medicine
- ❑ Antidepressants or tranquilizers
- ❑ Insulin, Orinase, or other diabetes drug
- ❑ Nitroglycerin
- ❑ Cortisone or other steroids
- ❑ Osteoporosis (bone density) medicine
- ❑ Cocaine
- ❑ Other:_______________________________________
  ____

Do you smoke or use chewing tobacco? ❑ yes ❑ no

Have you been advised by your physician to pre-medicate prior to dental treatments? ☐ Yes ☐ No

Dental History: Check only if the answer is yes.

- ❑ Gums bleed while brushing or flossing
- ❑ Teeth sensitive to hot/cold liquids or foods
- ❑ Teeth sensitive to sour/sweet liquids or foods
- ❑ Pain in any of your teeth
- ❑ Sores or lumps in or near your mouth
- ❑ Have you had any head, neck or jaw injuries
- ❑ Any jaw joint clicking or pain
- ❑ Any difficulty opening or closing mouth
- ❑ Any difficulty chewing
- ❑ Frequent headaches
- ❑ Do you clench or grind your teeth?
- ❑ Do you bite your lips or cheeks often?
- ❑ Have you ever had any difficult extractions?
- ❑ Have you had any orthodontic work?
- ❑ Have you ever had prolonged bleeding following an extraction?
- ❑ Have you ever had instruction on the correct method of brusing and flossing your teeth?
- ❑ Have you ever had instruction on the care of your gums?
- ❑ Have you ever had any complications following dental treatment?

Please explain:_______________________________________
____

- Have you been admitted into a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: ____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: ____
- Name of Physician:_______________________________________ Phone: ________________________
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: ____

*Please list any medications, including non-prescription drugs, taken on a regular basis_____________________________________
____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

____ Date: _______________

Print name of patient, parent or guardian Signature of patient, parent or guardian

For office use only: Reviewed by:______________________________________ Date__________________

Welcome to Dr. David A. Paulisin's office!
To assist us in serving you, please complete the following confidential forms.

Patient Information

Name: ____
☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other ____________________

Birth Date:__________________ Social Security # (Of Responsible Party if child) ________________________

Phone (Home): ______________ (Cell): ________________ (Work): ______________ (Extention):______

Address: ____
Street Apartment #

____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment Name______________________________

Employer Name: ________________________________ Occupation: ________________________

Address: ____
Street City, State Zip Code Phone

Insurance Information

Primary

Name of Insured: ________________________________ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: ______________ ID # or SS#________________ Group #: ________________

Insured's Address: ____
Street City State Zip Code

Insured's Employer Name: ____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other ______________

Insurance Plan Name and Address: ____

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Secondary

Name of Insured: ________________________________ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: ______________ ID # or SS#________________ Group #: ________________

Insured's Address: ____
Street City State Zip Code

Insured's Employer Name: ____

Address: ____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other ______________

Insurance Plan Name and Address: ____

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I accept full responsibility for all charges for services rendered by David A. Paulisin, DDS, PC. I agree to pay all costs of collection, including reasonable attorney fees. I authorize the release of medical information necessary for completion of insurance claim forms. I assign all benefits under my current health insurance policies and authorize payment directly to David A. Paulisin, DDS, PC. I understand any balance left after insurance has settled claim is my responsibility. I agree to promptly pay any outstanding balance. I understand that I will be charged a broken appointment fee without 24 hours notice. I understand that I will be charged $40 for a returned check plus any additional bank fees.
I have read all of the information on this form and agree to these policies.

____ Date: __________ Relationship to Patient: ______________________
Signature of patient, parent or guardian

____ Date: __________ Relationship to Patient: ______________________
Signature of guarantor of payment/responsible party

DAVID PAULISIN, DDS, PC
NOTICE OF PRIVACY PRACTICES

This Notice Describes How Health Information About You May be Used and Disclosed And How You Can Gain Access To This Information.

PLEASE REVIEW IT CAREFULLY
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US

OUR LEGAL DUTY
We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices. This notice takes effect April 14, 2003.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. Any changes will be made available to you.

You may request a copy of our privacy notice at any time.

USES AND DISCLOSURES OF HEALTH INFORMATION
We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

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 we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, 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 use or disclosures permitted by your authorization while it was in effect.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

N**ational Security**: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS
Access: You have the right to look at or get copies of your health information, with limited exceptions.

Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS
We support your right to the privacy of your health information. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information, you may complain to us using the contact information listed at the end of this notice.

Contact Officer: Office Manager
David Paulisin, DDS, PC
28807 Eight Mile Road, Suite 101
Livonia, MI 48152
Phone: (248) 516-5266
Fax: (248) 516-5267

DAVID PAULISIN, DDS, PC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse To Sign This Acknowledgement

I, ____, have received a copy of this office's
(Please Print Name)
Notice of Privacy Practices.

____

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 attained because:

- ❑ Individual refused to sign
- ❑ Communications barriers prohibited obtaining the acknowledgement
- ❑ An emergency situation prevented us from obtaining acknowledgement
- ❑ Other (Please Specify)

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