

DAVID C. CORMIER, D.D.S.

HEALTH HISTORY

Patient Name: _____ Soc. Sec. No.: _____ Date: _____

Phone: (____) _____ - _____ Birth Date: ____/____/____ Age: _____

I. Please mark the appropriate answer (leave blank if you do not understand question): _____

- 1. Yes No Is your general health good?
2. Yes No Has there been a change in your health within the last year?
3. Yes No Have you been hospitalized or had a serious illness in the last three years? Why?:
4. Yes No Are you being treated by a physician now? For What: Date of last Medical Exam: Physician's name: Phone #: Physician's address:
5. Yes No Have you had problems with anything prior to dental treatment?
6. Yes No Are you in pain now?

II. Have you experienced any of the following: _____

- 7. Yes No Chest pain (angina)
8. Yes No Swollen ankles
9. Yes No Shortness of breath
10. Yes No Recent weight loss, fever, night sweats
11. Yes No Persistent cough, coughing up blood
12. Yes No Bleeding problems, bruising easily
13. Yes No Sinus problems
14. Yes No Difficulty swallowing
15. Yes No Diarrhea, constipation, blood in stool
16. Yes No Frequent vomiting
17. Yes No Difficulty urinating, blood in urine
18. Yes No Dizziness
19. Yes No Ringing in ears
20. Yes No Headaches
21. Yes No Fainting spells
22. Yes No Blurred vision
23. Yes No Seizures, epilepsy
24. Yes No Excessive thirst
25. Yes No Frequent urination
26. Yes No Dry mouth
27. Yes No Jaundice
28. Yes No Joint pain, stiffness

III. Do you have or have you had any of the following: _____

- 29. Yes No Heart disease
30. Yes No Heart attack, heart defects
31. Yes No Heart murmurs, mitral valve prolapse
32. Yes No Rheumatic fever
33. Yes No Stroke, hardening of arteries
34. Yes No High blood pressure
35. Yes No TB, emphysema, other lung diseases
36. Yes No Hepatitis, other liver disease, jaundice
37. Yes No Stomach problems, ulcer
38. Yes No ALLERGIES: to drugs, foods, medications/others -
39. Yes No Family history of diabetes, heart problems, tumors -
40. Yes No AIDS, ARC, HIV infection
41. Yes No Tumors, cancer
42. Yes No Arthritis, rheumatism
43. Yes No Eye disease
44. Yes No Skin diseases
45. Yes No Anemia, blood disease
46. Yes No VD (syphilis, gonorrhea, Chlamydia)
47. Yes No Herpes
48. Yes No Kidney, bladder disease
49. Yes No Thyroid, adrenal glands
50. Yes No Diabetes

IV. Do you have or have you had any of the following: _____

- 51. Yes No Psychiatric care
52. Yes No Radiation treatments
53. Yes No Chemotherapy
54. Yes No Prosthetic heart valve
55. Yes No Artificial joint
56. Yes No Hospitalization
57. Yes No Blood transfusions
58. Yes No Surgeries
59. Yes No Pacemaker
60. Yes No Contact lenses

V. Do you use any of the following: _____

- 61. Yes No Recreational drugs
62. Yes No Drugs, medicines, (including Aspirin) Please List-
63. Yes No Tobacco in any form?
64. Yes No Alcohol?

VI. Women only: _____

- 65. Yes No Are you or could you be pregnant or nursing
66. Yes No Taking birth control pills

VII. All Patients: _____

- 67. Yes No Do you have or have you had any other diseases or medical problems NOT listed on this form? If so, please explain:

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any changes in my health and/or medication.

Patient's signature: _____ Date: _____

**AUTHORIZATION TO TRANSFER
DENTAL RECORDS**

PATIENT NAME _____

DATE OF BIRTH _____

SOCIAL SECURITY NUMBER _____

1. **AUTHORIZATION FOR RELEASE.** I hereby authorize David C. Cormier, D.D.S. of 495 Cabot Street, Suite 201, Beverly, Massachusetts 01915, to disclose and deliver the following information to:

AUTHORIZED RECIPIENT: _____

2. **SPECIFIC AUTHORIZATION.** I specifically authorize the release of all dental information relating to me including x-rays and any medical information that may be contained in my records. This information may include categories of substance abuse treatment, mental health treatment and HIV /AIDS related information if such information is contained in my record.

I do not give my permission for any other use or redisclosure of this information.

Date _____

Patient / Guardian Signature _____

Patient / Guardian Print Name _____

Patient Address _____

City, State, Zip _____

David Cormier, D.D.S.

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}

I authorize the following persons to have access to my protected health information _____

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)
- _____

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