

Do you have the following problems with your mouth or teeth? (Please circle)

Gums swollen	Gums bleed	Tooth sensitive to cold	Mouth dry	Gums burn or feel raw
Bad taste	Teeth feel loose	Tooth sensitive to hot	Bite feels funny	Areas constantly pack
Mouth ulcers	Jaw joints pop, click or hurt			

Please circle any of the following which you have had or have at the present:

Heart failure	Low blood pressure	HIV+ (Human Immunodeficiency)	Emphysema
Heart disease/attack	Artificial joint	Hepatitis A (Infectious)	Tuberculosis (TB)
Angina pectoris	Stroke	Hepatitis B (Serum)	Persistent cough
High blood pressure	Kidney trouble	Hepatitis C	Asthma
Heart murmur	Diabetes	Liver disease	Sinus trouble
Mitral valve prolapse	Anemia	Blood transfusion	Allergies or hives
Rheumatic fever	Cortisone medicine	Drug addiction	Hay fever
Congenital heart lesions	Thyroid disease	Hemophilia	Glaucoma
Artificial heart valve	Arthritis	Sickle cell disease	Ulcers
Heart pacemaker	Nervousness	Psychiatric treatment	Fainting or dizzy spells
Heart surgery	Epilepsy or seizures	Depression	Chemotherapy (Cancer, Leukemia)
		Cold sores	

Allergic to or unable to tolerate any medicines or anesthetics? No Allergies Yes If yes, please list

Physician _____ Last physical exam was on _____

Do you currently smoke? Yes No Have you smoked in the past? Yes No If yes, how much? _____

Are you in good health? Yes No

Are you having pain or discomfort at this time?..... Yes No

Do you feel nervous about having dental treatment?.....Yes No

Have you ever had an unpleasant experience in a dental office?.....Yes No

Have you been under the care of a medical doctor in the past two years?Yes No

Have you been a patient in the hospital in the past two years?.....Yes No

Do you ever wake up from sleep short of breath?.....Yes No

Are you on a special diet?..... Yes No

Have you ever been diagnosed with cancer or a tumor by your medical doctor?..... Yes No

Have you ever had any excessive bleeding requiring special treatment?.....Yes No

When you walk upstairs or take a walk, do you ever stop because of pain in your chest, shortness of breath, or because you are very tired?.....Yes No

Do you have any disease, condition or problem not listed?.....Yes No

If yes, please describe: _____

Please list any medication, vitamin or herbal supplements that you are presently taking? (Aspirin, etc.)

Are you pregnant? Yes No Not Applicable

Are you taking birth control pills? Yes No Not Applicable

Do you anticipate becoming pregnant? Yes No Not Applicable

Are there any other issues we should be aware of? _____

Kenneth J. Bodnar, DDS
Thomas M. Bodnar, DDS, MS
Practice Limited to Periodontics

Authorization and Release

I certify that I have read and understand the information completed to the best of my knowledge. The questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release my information including diagnosis and the records of any treatment or examination rendered to me or my dependent during the period of such Dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or any dependents. If I have a change in my health, I will inform Dr. Bodnar of this at the next appointment.

**HIPAA Patient Consent
The Health Insurance Portability and Accountability Act**

I understand that, under the **Health Insurance Portability & Accountability Act of 1996 (HIPAA)**, I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment for third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certification.

I have been informed by Dr. Bodnar of your Notice of Privacy Practices (located in the patient reception area) containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact the office at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my request restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Signature of Patient or Guardian _____ Date _____

Signature of Doctor _____