Medical History Form
Dzuban Dental Associates

300 Penn Center Blvd #210
Pittsburgh, PA 15235
412-825-0200 412-825-4627(fax)

Patient Name _____ Cell # _____

Email _____Home # _____

Street Address _____ City _____Zip _____

Date of Birth ____/____/____ ☐ Male ☐ Female

Insurance

Name of Dental Insurance _____

Policy Holder for Dental _____ Relationship to Insured ☐self ☐spouse ☐child

Employer _____

Name of Medical Insurance _____

Policy Holder for Medical _____ Relationship to Insured ☐self ☐spouse ☐child

Physician Name _____ Phone # _____

Indicate which of the following conditions you have or have had. By checking the box it will indicate a "YES" response, leaving it blank will indicate a "NO" response.

- ☐ Pre-Med
- ☐ Allergy-Celiac/Gluten
- ☐ Angina
- ☐ Artificial Joints
- ☐ Blood Pressure-Low
- ☐ Circulatory Problems
- ☐ Excessive Bleeding
- ☐ Headaches
- ☐ Hepatitis
- ☐ Liver Disease
- ☐ Nervous Disorders
- ☐ Pregnancy
- ☐ Sinus Problems
- ☐ Sleep Apnea
- ☐ Stroke/TIA
- ☐ Tuberculosis
- ☐ Hospitalized
- ☐ Bite Appliance
- ☐ Acid reflux/GERD
- ☐ Allergy to Medicine
- ☐ Anxiety/Depression
- ☐ Asthma
- ☐ Cancer
- ☐ Diabetes
- ☐ Fibromyalgia
- ☐ Heart Disease
- ☐ High Cholesterol
- ☐ Memory Loss
- ☐ Organ Transplant
- ☐ Radiation Treatments
- ☐ Sjogrens
- ☐ Sleep Apnea-CPAP
- ☐ Swelling/Feet/Ankles
- ☐ Tumors
- ☐ Under Doctor care
- ☐ Orthodontic Treatment
- ☐ ADD/ADHD
- ☐ Allergy-Latex
- ☐ Arrythmia (Afib)
- ☐ Back Problems
- ☐ Chemical Dependency
- ☐ Dizziness/Fainting
- ☐ Glaucoma
- ☐ Heart Murmur
- ☐ Jaw Pain
- ☐ Mental Illness
- ☐ Osteoporosis
- ☐ Respiratory Problems
- ☐ Skin Rash
- ☐ Snore
- ☐ Thyroid Problems
- ☐ Ulcers
- ☐ Oral Surgery
- ☐ AIDS/HIV
- ☐ Allergy-Penicillin
- ☐ Arthritis
- ☐ Blood Pressure-High
- ☐ Chemotherapy
- ☐ Epilepsy/Seizures
- ☐ Head injuries
- ☐ Hemophilia
- ☐ Kidney Disease
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Shortness of Breath
- ☐ Stent
- ☐ Stomach Problems
- ☐ Tobacco Habit
- ☐ Valve Replacement
- ☐ Vaping

(OVER)

Do you take antibiotic premedication for your dental visits? _____YES _____No If yes, please explain.

PRE-MED _____

Are you currently taking any medications, prescription and/or non-prescription? _____YES_____NO If yes, please explain.

MEDICATIONS

_____

_____

_____

Do you have any allergies? _____YES _____NO

ALLERGIES

_____

_____

Describe any current medical treatment or impeding surgery that may possibly affect your dental treatment.

_____

_____

☐ By checking this box, I acknowledge that I have reviewed ALL questions on this questionnaire and responded accordingly. There are no other medical conditions/allergies that have not been listed. I am aware that I must notify the practice of any future changes.

About HIPAA Privacy

The Privacy Rule provides federal protections for personal health information held by covered entities and gives patients an array of rights with respect to that information. At the same time, the Privacy Rule is balanced so that it permits the disclosure of personal health information needed for patient care and other important purposes.

Your Health Information is Protected by Federal Law

Most of us believe that our medical and other health information is private and should be protected, and we want to know who has this information. The Privacy Rule, a Federal law, gives you rights over your health information and sets rules and limits on who can look at and receive your health information.

What Information is Protected?

- Information your doctors, nurses, and other health care providers put in your medical record
- Conversations your doctor has about your care or treatment with nurses and others
- Information about you in your health insurer's computer system
- Billing information about you at your clinic
- Most other health information about you held by those who must follow this law

How is This Information Protected?

- Covered entities must put in place safeguards to protect your health information.
- Covered entities must reasonably limit uses and disclosures to the minimum necessary to accomplish their intended purpose.
- Covered entities must have contracts in place with their contractors and others ensuring that they use and disclose your health information properly and safeguard it appropriately.
- Covered entities must have procedures in place to limit who can view and access your health information as well as implement training programs for employees about how to protect your health information.

What Rights Does This Law Give Me Over My Health Information?
Health Insurers and Providers who are covered entities must comply with your right to:

- Ask to see and get a copy of your health records
- Have corrections added to your health information
- Receive a notice that tells you how your health information may be used and shared
- Decide if you want to give your permission before your health information can be used or shared for certain purposes, such as for marketing
- Get a report on when and why your health information was shared for certain purposes
- If you believe your rights are being denied or your health information isn't being protected, you can:
    - File a complaint with your provider or health insurer
    - File a complaint with the U.S. Government

You should get to know these important rights, which help you protect your health information. You can ask your provider or health insurer questions about your rights.

Who Can Look at and Receive Your Health Information
The law sets rules and limits on who can look at and receive your health information. To make sure that your health information is protected in a way that does not interfere with your health care, your information can be used and shared:

- For your treatment and care coordination
- To pay doctors and hospitals for your health care and to help run their businesses
- With your family, relatives, friends, or others you identify who are involved with your health care or your health care bills, unless you object
- To make sure doctors give good care and nursing homes are clean and safe
- To protect the public's health, such as by reporting when the flu is in your area
- To make required reports to the police, such as reporting gunshot wounds

Your health information cannot be used or shared without your written permission unless this law allows it. For example, without your authorization, your provider generally cannot:

- Give your information to your employer
- Use or share your information for marketing or advertising purposes
- Share private notes about your health care

Personal Health Information Release Form

(HIPAA Release Form)

Name: _____ Date of Birth: ____/____/____

Release of Information

[ ] I authorize the release of any and all information including diagnosis, financial, dental records, examinations rendered to me and claims information. This information may be released to:

[ ] Spouse _____

[ ] Child(ren) _____

[ ] Other _____

[ ] Information is not to be released to anyone.