DENTAL HEALTH HISTORY
(Confidential)

Patient Information (Please complete both sides)

Last Name (Mr. Mrs. Ms. Dr.)_____

First Name _____

Birthdate_____/_____/_____Age_____

Home Address_____

City _____ State _____ Zip _____

Phone Hm: ( ) _____ Cell: ( ) _____

e-mail_____

Soc. Sec. #_____

Spouse's Name_____

Birthdate_____/_____/_____Age_____

Soc. Sec. #_____

Responsible Party If Patient Is A Minor_____

If Student, College Attending_____, City:_____

Employment

Occupation _____

Employer_____

Work Address _____

City _____ State _____ Zip _____

Work Phone ( ) _____

Spouse's Employment

Occupation _____

Employer Name _____

Work Address _____

City _____ State _____ Zip _____

Phone ( ) _____

Insurance Information: (If you have dental insurance, please complete the following and apprise us as any changes occur in your coverage)

Primary Coverage

Subscriber's Name_____

Employer_____

Insurance Company_____

Insurance Phone Number:_____

Group or policy #_____

Subscriber's ID# or Soc. Sec. # _____

Subscriber's Birthdate if not given above_____

Secondary Coverage

Subscriber's Name_____

Employer_____

Insurance Company_____

Insurance Phone Number:_____

Group or policy #_____

Subscriber's ID# or Soc. Sec. # _____

Subscriber's Birthdate if not given above_____

Referred By: _____

Medical History: ***There are many medical situations which can affect or be affected by the procedures or drugs used for dentistry. Therefore, please fill out the following carefully. Thank-you***

Date of last medical exam _____/___/_____ Physician's Name _____ Phone ( ) _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include the combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine) ☐ Yes ☐ No

Have you had any serious illnesses or operations ? _____If yes, describe_____

_____

Medications

List medications you are currently taking:

_____

_____

Pharmacy Name _____

Phone ( )_____

Allergies: Have you experienced an allergic or unusual reaction to:

☐ Aspirin
☐ Codeine
☐ Dental Anesthetics
☐ Tetracycline
☐ Erythromycin
☐ Penicillin
☐ sedatives/sleeping pills
☐ Other Medications: _____
☐ _____
☐ _____

Do you have or have you had any of the following

	Yes	No		Yes	No		Yes	No	**Are You**	Yes	No
Asthma	☐	☐	Tuberculosis	☐	☐	Low Blood Pressure	☐	☐	Often thirsty	☐	☐
Allergy	☐	☐	Thyroid Trouble	☐	☐	High Blood Pressure	☐	☐	Urinating 6+/day	☐	☐
Diabetes	☐	☐	Sinus Trouble	☐	☐	Blood transfusions	☐	☐	Often exhausted	☐	☐
Hepatitis	☐	☐	Kidney Trouble	☐	☐	Prolonged Bleeding	☐	☐	A Smoker	☐	☐
Jaundice	☐	☐	Heart Trouble	☐	☐	Radiation Therapy	☐	☐	Generally nervous	☐	☐
Anemia	☐	☐	Liver Trouble	☐	☐	Psychiatric Care	☐	☐	Often unhappy/depressed	☐	☐
Stroke	☐	☐	Prosthetic valve	☐	☐	Rheumatic Fever	☐	☐			
Arthritis	☐	☐	Heart Murmur	☐	☐	Fainting Spells	☐	☐	**If Female, are you now**	**Yes**	**No**
Seizures	☐	☐	Epilepsy	☐	☐	Persistent Cough	☐	☐	Pregnant	☐	☐
Glaucoma	☐	☐	Herpes	☐	☐	Tumor Benign/Malign	☐	☐	Taking birth control pills	☐	☐
Arteriosclerosis	☐	☐	Swollen ankles	☐	☐	Shortness of breath	☐	☐	Presently in menopause	☐	☐
Contact lenses	☐	☐	Chest pain	☐	☐	Hives, skin rash, hay fever	☐	☐	Past menopause	☐	☐
Venereal Disease	☐	☐	Emphysema	☐	☐	Head or Neck Injuries	☐	☐			
Ulcer	☐	☐	Scarlet Fever	☐	☐	HIV Positive	☐	☐	**Male**	**Yes**	**No**
Chemotherapy	☐	☐	Prosthetic Joint	☐	☐	Substance abuse (alcohol, drugs)	☐	☐	Prostate Disorders	☐	☐

Dental History

Last Dental Exam _____/____/_____ Former Dentist _____ Phone ( )_____

How often do you have your teeth cleaned? ☐ 3 months ☐ 4 months ☐ 6 months ☐ 1 year

Any previous major dental treatment? ☐ Yes ☐ No If yes, when? _____/____/_____

Do you have or do you use any of the following

☐ **Teeth sensitive to cold, heat, sweets or pressure**	☐ **Pain around ear**	☐ **Periodontal treatment**
☐ Bleeding Gums. How long? _____	☐ Unusual sounds in ear when eating	☐ Orthodontic treatment
☐ Food impaction (collection between teeth)	☐ Unhappy with appearance	☐ Mouth breathing
☐ Clenching or Grinding	☐ Bad breath	☐ Oral habits, i.e. fingernail biting, cheek biting, etc…
☐ Burning of tongue	☐ Unpleasant taste	☐ Texture of toothbrush ☐ soft ☐ medium ☐ hard
☐ Swelling or lumps in mouth	☐ Unfavorable dental experience	☐ Frequency of brushing _____ per day
☐ Frequent blisters on lips or mouth	☐ Complications from extraction(s)	☐ Dental floss
☐ Interdental stimulators	☐ Water jet device	☐ Disclosing tablets or solution
☐ Fluoride supplements	☐ T.M.J. (jaws) treatment	☐ Loose teeth or broken fillings

Consent: I, (patient name) _____, hereby authorize Dr. Fella Benyammi to take necessary X-Rays, study models, photographs or any other diagnostic aids deemed appropriate by Dr. Fella Benyammi to make a thorough diagnosis of my dental needs. I also authorize Dr. Fella Benyammi to perform any and all forms of treatment, medication and therapy that may be indicated in connection with me and further authorize and consent that Dr. Fella Benyammi may use employees for assistance as she deems fit. I also understand the use of anesthetic agents embodies a certain risk. I recognize that I am financially responsible for any services rendered to me or my dependents at this office. I understand that payment is due and payable at the time of service unless financial arrangements have been made. As a special service to me, insurance claims may be prepared and submitted on my behalf. I hereby authorize this office to release any information to my insurance company that is needed for the filling of my claims.

Patient Signature: _____ **Date:** _____

Parent/Guardian: _____ **Relationship _____**

Dr. Benyammi's Signature: _____ **Date:** _____

Patient Acknowledgement of Receipt of the Dental Materials Fact Sheet

I, _____, acknowledge that I received from Fella Benyammi, DDS, a copy of the Dental Materials Fact Sheet dated October, 2001.

Date _____

Patient's Signature _____

Acknowledgment of Receipt or Review of Notice of Privacy Practices

I, _____, have received or reviewed a copy of this office's Notice of Privacy Practices.

Signature: _____ **Date:** _____

Applies to the following family members or dependents: (list below)

1. _____
2. _____
3. _____
4. _____

Authorization and Consent for Use and Disclosure of Health Information

Name: _____ SS#: _____

Address: _____

Phone: _____

Purpose of Consent: By signing this form, you will authorize and consent to our use of your protected health information to carry out treatment, payment activities, and healthcare operations on your behalf.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before signing this form. Our Notice provides a description of our treatment, payment activities, and healthcare operations of the uses and disclosures we may make of your protected health information, and of other related matters to your health information. We encourage you to read this notice carefully and completely before signing this Authorization and Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we elect to change our privacy practices, we will issue a revised Notice of Privacy Practices and inform you about any changes. The changes may pertain to any protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions, by contacting our office:
Fella Benyammi, DDS
Address: 777 Cuesta Drive, Suite 140, Mountain View, CA 94040
Phone: (650) 254-1596

Revocation: You have the right to revoke this Authorization and Consent at any time by giving us a **written request**, sent to the Doctor's office listed above. Please understand that revocation of the Authorization and Consent will not affect any action taken prior the receipt of your revocation.

I, _____, have read the contents of this Authorization and Consent form and Notice of Privacy Practices. I understand that by signing this Authorization and Consent form, I am giving my authorization and consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations. Please be assured that we will not allow any unauthorized uses or disclosures of your health records that will adversely affect you or your family.

Signature: _____ **Date:** _____

If guardian, please complete the following:
Guardian's Name: _____
Relationship to Patient: _____

For Office Use Only: Acknowledgment/Authorization/Consent not obtained because:

- ☐ Individual refused to sign
- ☐ Communications barrier prohibited obtaining acknowledgment
- ☐ Emergency situation prevented obtaining acknowledgment
- ☐ Other (Specify) _____