MEDICAL HISTORY

Patient Name: _____ Birth Date: _____ Today's Date: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or edication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Physician's Name: _____ Physician's Phone #: _____

Are you under a physician's care now?	○ Yes ○ No	If yes
Have you ever been hospitalized or had a major operation?	○ Yes ○ No	If yes
Are you taking any medications, pills, or drugs?	○ Yes ○ No	If yes
Pharmacy Name_____		
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○ Yes ○ No	If yes
Are you on a special diet?	○ Yes ○ No	
Do you use tobacco?	○ Yes ○ No	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Metal
☐ Latex	☐ Sulfa drugs	☐ Local Anesthetics	☐ Nuts
☐ Milk			

Do you use controlled substances?	○ Yes ○ No	If yes
Do you use alcohol? How often?	○ Yes ○ No	If yes

Do you have or have you had, any of the following?

AIDS/HIV Positive	○ Yes ○ No	Cortisone Medicine	○ Yes ○ No	Hemophilia	○ Yes ○ No	Radiation Treatments	○ Yes ○ No
Alzheimer's Disease	○ Yes ○ No	Diabetes	○ Yes ○ No	Hepatitis A	○ Yes ○ No	Recent Weight Loss	○ Yes ○ No
Drug Addition	○ Yes ○ No	Hepatitis B or C	○ Yes ○ No	Renal Dialysis	○ Yes ○ No	Anemia	○ Yes ○ No
Herpes	○ Yes ○ No	Rheumatic Fever	○ Yes ○ No	Angina	○ Yes ○ No	Emphysema	○ Yes ○ No
High Blood Pressure	○ Yes ○ No	Rheumatism	○ Yes ○ No	Arthritis/Gout	○ Yes ○ No	Epilepsy or Seizures	○ Yes ○ No
High Cholesterol	○ Yes ○ No	Scarlet Fever	○ Yes ○ No	Artificial Heart Valve	○ Yes ○ No	Excessive Bleeding	○ Yes ○ No
Hives or Rash	○ Yes ○ No	Shingles	○ Yes ○ No	Artificial Joint	○ Yes ○ No	Excessive Thirst	○ Yes ○ No
Hypoglycemia	○ Yes ○ No	Asthma	○ Yes ○ No	Fainting Spells/Dizziness	○ Yes ○ No	Irregular Heartbeat	○ Yes ○ No
Sinus Trouble	○ Yes ○ No	Blood Disease	○ Yes ○ No	Frequent Cough	○ Yes ○ No	Kidney Problems	○ Yes ○ No
Blood Transfusion	○ Yes ○ No	Frequent Diarrhea	○ Yes ○ No	Leukemia	○ Yes ○ No	Stomach/Intestinal Disease	○ Yes ○ No
Breathing Problems	○ Yes ○ No	Frequent Headaches	○ Yes ○ No	Liver Disease	○ Yes ○ No	Stroke	○ Yes ○ No
Bruise Easily	○ Yes ○ No	Genital Herpes	○ Yes ○ No	Low Blood Pressure	○ Yes ○ No	Swelling of Limbs	○ Yes ○ No
Cancer	○ Yes ○ No	Glaucoma	○ Yes ○ No	Lung Disease	○ Yes ○ No	Thyroid Disease	○ Yes ○ No
Chemotherapy	○ Yes ○ No	Hay Fever	○ Yes ○ No	Mitral Valve Prolapse	○ Yes ○ No	Tonsillitis	○ Yes ○ No
Chest Pains	○ Yes ○ No	Heart Attack/Failure	○ Yes ○ No	Osteoporosis	○ Yes ○ No	Tuberculosis	○ Yes ○ No
Cold Sores/Fever Blisters	○ Yes ○ No	Heart Murmur	○ Yes ○ No	Pain in Jaw Joints	○ Yes ○ No	Tumors or Growths	○ Yes ○ No
Congenital Heart Disorder	○ Yes ○ No	Heart Pacemaker	○ Yes ○ No	Ulcers	○ Yes ○ No	Convulsions	○ Yes ○ No
Heart Trouble/Disease	○ Yes ○ No	Psychiatric Care	○ Yes ○ No	Venereal Disease	○ Yes ○ No	Yellow Jaundice	○ Yes ○ No

Have you ever had any serious illness not listed ○ Yes ○ No If yes

History Review:

Dr's. Signature: _____ Date: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature Of Patient, Parent, or Guardian:

X Date: _____

PATIENT RESPONSIBILITY FORM

1. INDIVIDUAL'S FINANCIAL RESPONSIBILITY

- I understand that I am financially responsible for my dental insurance deductible, coinsurance or non-covered service.
- Co-payments are due at time of service.
- In the event that my dental plan determines a service to be "not payable", I will be responsible for the complete charge and agree to pay the costs of all services provided.
- If I am uninsured, I agree to pay for the dental services rendered to me at the time of service.

2. INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

I hereby authorize and direct payment of my dental benefits to Damian K. Jones, D.D.S., P.L.L.C. and Philip J. Leta, D.D.S. on my behalf for any services furnished to me by the providers.

3. AUTHORIZATION TO RELEASE RECORDS

I hereby authorize Damian K. Jones, D.D.S., P.L.L.C. and Philip J. Leta, D.D.S. to release to my insurer, governmental agencies or any other entity financially responsible for my dental care, all information, including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for such dental services as well as information required for precertification, authorization or referral to other dental provider.

4. MEDICARE REQUEST FOR PAYMENT

I request payment of authorized Medicare benefits to me or on my behalf for any services furnished me by or in Damian K. Jones, D.D.S., P.L.L.C. and Philip J. Leta, D.D.S. I authorize any holder of dental or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

_____ _____

Signature of Patient, Authorized Representative or Responsible Party — Date

_____ _____

Print Name of Patient, Authorized Representative or Responsible Party — Relationship to Patient

Damian K. Jones, D.D.S., P.L.L.C.
Philip J. Leta, D.D.S.

Cancellation Policy

This letter is to inform our patients of a change in policy. Last minute cancellations and no show appointments are a major problem. We ask that you please give the office 48 hour notice of an appointment change.

We are sensitive to the fact that emergencies do arise. However, some of our patients have a chronic history of no shows or last minute cancellations. As of JANUARY 1st, 2018, we reserve the right to charge a $30 missed appointment/cancellation fee for cancellation without 24 hour notice.

Thank you for your understanding in this policy change.

Patient Signature: _____

Date: _____

7208 Buffalo Avenue
Niagara Falls, NY 14304
(716) 283-3314
(716) 283-8367 fax

THE OFFICE OF DAMIAN JONES, D.D.S., P.L.L.C. AND PHILIP J. LETA, D.D.S.

PRIVACY NOTICE

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal healthcare records are protected. The rule, also known as HIPAA, was also created in order to provide standards for health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, and/or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information, information about treatment, payment, or health care operations, in order to provide care that is in your best interest. We also want you to know that we support your full access to your Personal medical records.

You may refuse to consent to the use or disclosure of your Personal Health Information (PHI), but this must be in writing. Under this law, we have the right to refuse to treat you should you refuse to disclose your personal health information. If you choose to give consent in this document, at some future time you may submit a written request to refuse disclosure of all or part of your PHI. It would become effective the date the written notice was received. You may not revoke actions that have already been taken with regarding your PHI, which relied on this or a previously signed consent. Please note that there are certain medical facilities that we deal with that are not required to obtain patient consent.

You have the right to review our privacy notice in its entirety, to request restrictions, and revoke consent in writing after you have reviewed our privacy notice. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

Below, please list family members or friends who may discuss your PHI (such as office appointments, questions about your case, or insurance issues that may arise).

Print name of person : _____ Relationship:_____

Print name of person: _____ Relationship:_____

Print your Name:_____

Signature:_____ Date:_____

Witness:_____ Date:_____