Drs. Badri Debian, Robert Liptak, John Griffin and Louis Rigali

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I. PATIENT INFORMATION RECORD

Name_____ Age_____-M___F___ Marital Status_____
D.O.B.____/____/_____ SS#_____ Name of Spouse_____
Address_____ City/State/Zip_____
Home Phone ( )_____ Cell Phone ( )_____ Work Phone ( )_____
Parent/Legal Guardian_____

In case of emergency please notify:
Name_____ Tel ( )_____ Relationship_____
Primary Care Physician_____

Patient's Employer_____ Occupation_____
Responsible Party Name_____ Employer_____
Full-time College Student?_____ If yes, School & Address_____
_____

II. INSURANCE INFORMATION

Dental Insurance Carrier_____ Cov'd Subscriber_____
Subscriber ID#/SS#_____Subscriber D.O.B._____
Group/Plan#_____ Subscriber Employer_____

Method of Payment: _____Cash _____Master Card _____Visa _____Discover
_____American Express _____Care Credit _____Debit Card _____ Personal Ck

III. MEDICAL HISTORY

High Blood Pressure	_____	Mental Health Issues	_____	Are you taking Coumadin?	_____
Heart Attack	_____	Epilepsy	_____	Do you take aspirin?	_____
Heart Murmur	_____	Recent Wt loss/gain	_____	Do you take Fosamax?	_____
Congenital Heart Defects	_____	Depression	_____	Do you take Boniva?	_____
Hx of Endocarditis	_____	Seizures	_____	Any other bisphosphonates?	
Pacemaker	_____	Arthritis	_____	Name_____	
Mitral Valve Prolapse	_____	Osteoporosis	_____	Have you/Do you smoke?	_____
Defibrillator	_____	Hayfever/Seasonal		Use controlled substances?	_____
Low Blood Pressure	_____	or Food Allergies	_____	Narcotics/Recreational drugs?	
Thyroid Disease	_____	Joint Replacement	_____	_____	
Angina	_____	Cancer (type)_____		Chew tobacco?	_____
Emphysema	_____	Hepatitis	_____	Women:	
Chemotherapy/Radiation	_____	HIV/AIDS	_____	Are you pregnant?	_____
Asthma	_____	Herpes	_____	Due Date _____	
Glaucoma	_____	Sexually Trans Disease	_____	Birth Control Pills?	_____
Kidney Disease	_____	History of Shingles	_____		
Liver Disease	_____	Tuberculosis	_____		
Respiratory Disease	_____	Bulemia/Anorexia	_____	***Allergic or have you had reaction***	
Stroke	_____	Neurological Disease	_____	***to: Latex_____ Sulfa Drugs_____***	
Diabetes	_____	Ulcers	_____	***Local Anesthesia_____ Penicillin***	
Leukemia	_____	Anemia	_____	***_____Metal (nickel, mercury, etc.)***	
Blood Disorder	_____			***Any antibiotics_____***	

*Signature*_____*Date*_____*Doctor's Initials*_____

Please list all medications, vitamins and/or herbal supplements you are currently taking:

_____

_____

_____

_____

_____

_____

_____

I understand the importance of a truthful health history to assist the Doctor in providing the best care possible. I have had the opportunity to discuss my health history with my Doctor.

_____

Signature of person completing health history Dr's Initials

IV. SIGNATURE ON FILE FORM

I authorize Holyoke Dental Associates to release medical or other information (which may include photocopies of medical and/or dental histories, x-ray findings, photos or CDs, diagnosis, treatment, prognosis and financial records) without limitation to determine benefits for treatment or a related insurance claim.

I permit a copy of this authorization to be used in place of the original, and request payment of benefits to the party who accepts assignment.

I am aware that I am responsible for any and all charges not covered by my Insurance Company or other third party payer.

V. AUTHORIZATION TO SHARE PRIVATE HEALTH INFORMATION (OPTIONAL)

If you wish to grant permission to our staff to speak with a friend or family member regarding your private health information – including your billing account – please complete the following. It will be in effect until it is revoked by you or updated with new information, whichever comes first.

If you leave this section blank, it will be considered a revocation of any previous authorization:

I give permission to the staff of BZD Dental Associates/Holyoke Dental Associates to release my private health information and billing account information to the following individual(s):

Name_____ Relationship_____

_____

Signature of **Patient**, if minor, parent signature_____

HIPAA Consent

- When you receive treatment at Holyoke Dental Associates, information will be collected about you, and this office will generate information about your medical condition. This private health information falls under Federal regulation within a law called the Health Information Portability and Accountability Act (HIPAA). **This information may be used or disclosed for treatment, payment, or to carry out healthcare operations.**
- There is a Notice of Privacy Practices posted in this office and available to you regarding the use of your private medical information. You have a right to review this document before giving consent for your care.

- You have the right to request that Holyoke Dental Associates restrict how your medical/dental information is used or disclosed, but Holyoke Dental Associates has the right not to agree with your request. If the practice (Holyoke Dental Associates) agrees to the restrictions, they are binding on the dentists, providers and staff.
- You have the right to revoke your consent to use your health information, except to the extent that your provider has already taken action based on previous consent.
- If you do not consent to this health information policy, Holyoke Dental Associates reserves the right not to provide care to you and to arrange care from another dental practice. We will not restrict or refuse your care in a medical/dental emergency.

Signature of Patient, Parent or Guardian_____