MEDICAL HISTORY

PATIENT NAME	NICKNAME:	DATE OF BIRTH:
NAME OF PHYSICIAN & THEIR SPECIALTY	MOST RECENT PHYSICAL EXAMINATION:	
PURPOSE:	ESTIMATE OF YOUR GENERAL HEALTH: EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR ☐	

	DO YOU HAVE or HAVE YOU EVER HAD:	YES	NO
1	HOSPITALIZATION FOR ILLNESS OR INJURY	☐	☐
2	AN ALLERGIC REACTION TO:	☐	☐
	ASPIRIN, IBUPROFEN, ACETAMINOPHEN	☐	☐
	PENICILLIN	☐	☐
	ERYTHROMYCIN	☐	☐
	TETRACYCLINE	☐	☐
	CODEINE	☐	☐
	LOCAL ANESTHETIC	☐	☐
	FLUORIDE	☐	☐
	METALS (GOLD, STAINLESS STEEL)	☐	☐
	LATEX	☐	☐
	ANY OTHER MEDICATIONS _____		
	_____		
3	HEART PROBLEMS	☐	☐
4	HEART MURMUR	☐	☐
5	RHEUMATIC FEVER	☐	☐
6	SCARLET FEVER	☐	☐
7	HIGH BLOOD PRESSURE	☐	☐
8	LOW BLOOD PRESSURE	☐	☐
9	A STROKE	☐	☐
10	ARTIFICIAL PROSTHESIS (I.E. HEART VALVE OR JOINTS)	☐	☐
11	ANEMIA OR OTHER BLOOD DISORDER	☐	☐
12	PROLONGED BLEEDING DUE TO A SLIGHT CUT	☐	☐
13	EMPHYSEMA	☐	☐
14	TUBERCULOSIS	☐	☐
15	ASTHMA	☐	☐
16	BREATHING OR SLEEP PROBLEMS (I.E. SNORING, SINUS)	☐	☐
17	KIDNEY DISEASE	☐	☐
18	LIVER DISEASE	☐	☐
19	JAUNDICE	☐	☐
20	THYROID OR PARATHYROID DISEASE	☐	☐
21	HORMONE DEFICIENCY	☐	☐
22	HIGH CHOLESTEROL	☐	☐

	DO YOU HAVE or HAVE YOU EVER HAD:	YES	NO
23	DIABETES	☐	☐
24	STOMACH OR DUODENAL ULCER	☐	☐
25	DIGESTIVE DISORDERS (I.E. GASTRIC REFLUX)	☐	☐
26	OSTEOPOROSIS/OSTEOPENIA	☐	☐
27	ARTHRITIS	☐	☐
28	GLAUCOMA	☐	☐
29	CONTACT LENSES	☐	☐
30	EPILEPSY, CONVULSIONS (SEIZURES)	☐	☐
31	NEUROLOGIC PROBLEMS	☐	☐
32	VIRAL INFECTIONS / COLD SORES	☐	☐
33	ANY LUMPS OR SWELLING IN MOUTH	☐	☐
34	HIVES, SKIN RASH, HAY FEVER	☐	☐
35	HEPATITIS (TYPE _____)	☐	☐
36	HIV / AIDS	☐	☐
37	TUMOR, ABNORMAL GROWTH	☐	☐
38	RADIATION THERAPY	☐	☐
39	CHEMOTHERAPY	☐	☐
40	PSYCHIATRIC TREATMENT	☐	☐
41	ANTIDEPRESSANT MEDICATION	☐	☐
42	ALCOHOL / DRUG DEPENDENCY	☐	☐
43	DO YOU USE TOBACCO	☐	☐
		☐	☐
	ARE YOU:	☐	☐
44	PRESENTLY BEING TREATED FOR ANY OTHER ILLNESS	☐	☐
45	AWARE OF A CHANGE IN YOUR GENERAL HEALTH	☐	☐
46	TAKING MEDICATION FOR WEIGHT MANAGEMENT	☐	☐
47	TAKING DIETARY SUPPLEMENTS	☐	☐
48	OFTEN EXHAUSTED OR FATIGUED	☐	☐
49	SUBJECT TO FREQUENT HEADACHES	☐	☐
50	A SMOKER OR SMOKED PREVIOUSLY	☐	☐
51	FEMALE - TAKING BIRTH CONTROL PILLS	☐	☐
52	FEMALE - PREGNANT	☐	☐
53	MALE - PROSTATE DISORDERS	☐	☐

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

_____

_____

List any medications, supplements, and/or vitamins taken within the last two years.

Drug	Purpose	Drug	Purpose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

DENTAL HISTORY

REFERRED BY:	HOW WOULD YOU RATE THE CONDITION OF YOUR MOUTH: EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR ☐
PREVIOUS DENTIST:	HOW LONG HAVE YOU BEEN A PATIENT (MONTHS/YEARS):
DATE OF MOST RECENT DENTAL EXAM:	DATE OF MOST RECENT X-RAYS:
I ROUTINELY SEE MY DENTIST EVERY: 3 MONTHS ☐ 4 MONTHS ☐ 6 MONTHS ☐ 12 MONTHS ☐	NOT ROUTINELY ☐

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:	**YES**	**NO**
PERSONAL HISTORY		
ARE YOU FEARFUL OF DENTAL TREATMENT? (SCALE OF 1-10, 10 BEING VERY FEARFUL) (CIRCLE ONE) 1 2 3 4 5 6 7 8 9 10		
HAVE YOU HAD UNFAVORABLE DENTAL EXPERIENCE?	☐	☐
HAVE YOU EVER HAD COMPLICATIONS FROM PAST DENTAL TREATMENT?	☐	☐
HAVE YOU EVER HAD TROUBLE GETTING NUMB OR REACTIONS TO LOCAL ANESTHETIC?	☐	☐
DID YOU HAVE BRACES, ORTHODONTIC TREATMENT, OR HAD YOUR BITE ADJUSTED?	☐	☐
HAVE YOU HAD ANY TEETH REMOVED?	☐	☐
SMILE CHARACTERISTICS		
IS THERE ANYTHING ABOUT THE APPEARANCE OF YOUR TEETH THAT YOU WOULD LIKE TO CHANGE?	☐	☐
HAVE YOU EVER WHITENED (BLEACHED) YOUR TEETH?	☐	☐
ARE YOU SELF CONSCIOUS ABOUT YOUR TEETH?	☐	☐
HAVE YOU BEEN DISAPPOINTED WITH THE APPEARANCE OF PREVIOUS DENTAL WORK?	☐	☐
WOULD YOU LIKE YOUR TEETH STRAIGHTER?	☐	☐
DO YOU HAVE MISSING TEETH THAT YOU WOULD LIKE TO REPLACE?	☐	☐
DO YOU HAVE ANY OLD SILVER FILLINGS THAT YOU WOULD LIKE TO REPLACE WITH TOOTH COLORED FILLINGS?	☐	☐
IF YOU COULD CHANGE ANYTHING ABOUT YOUR SMILE WHAT WOULD YOU CHANGE?_____		
_____		
BITE AND JAW JOINT		
DO YOU / WOULD YOU HAVE ANY PROBLEMS CHEWING GUM?	☐	☐
DO YOU / WOULD YOU HAVE ANY PROBLEMS CHEWING BAGELS OR OTHER HARD FOODS?	☐	☐
HAVE YOUR TEETH CHANGED IN THE LAST 5 YEARS, BECOME SHORTER, THINNER, OR WORN?	☐	☐
ARE YOUR TEETH CROWDING OR DEVELOPING SPACES?	☐	☐
DO YOU HAVE MORE THAN ONE BITE, OR DO YOU CLENCH (SQUEEZE) TO MAKE YOUR TEETH FIT TOGETHER?	☐	☐
DO YOU HAVE ANY PROBLEMS WITH SLEEP, OR WAKE UP WITH AN AWARENESS OF YOUR TEETH?	☐	☐
DO YOU HAVE PROBLEMS WITH YOUR JAW JOINT? (PAIN, SOUNDS, LIMITED OPENING, LOCKING, POPPING)	☐	☐
DO YOU HAVE TENSION HEADACHES OR SORE TEETH?	☐	☐
DO YOU WEAR OR HAVE YOU WORN A BITE APPLIANCE?	☐	☐
DO YOU BITE YOUR LIPS OR CHEEKS OFTEN?	☐	☐
TOOTH STRUCTURE		
HAVE YOU HAD ANY CAVITIES WITHIN THE PAST 3 YEARS?	☐	☐
DO YOU HAVE A DRY MOUTH?	☐	☐
ARE ANY TEETH SENSITIVE TO HOT, COLD, BITING, OR SWEETS?	☐	☐
HAVE YOU EVER HAD A TOOTHACHE, CRACKED FILLING, BROKEN, CHIPPED, OR CRACKED TOOTH?	☐	☐
DO YOU AVOID BRUSHING ANY PART OF YOUR MOUTH?	☐	☐
DO YOU FEEL OR NOTICE ANY HOLES (I.E. PITTING) IN YOUR TEETH?	☐	☐
DO YOU FEEL PAIN IN YOUR TEETH?	☐	☐
GUM AND BONE		
HAVE YOU EVER BEEN DIAGNOSED OR TREATED FOR PERIODONTAL (GUM) DISEASE?	☐	☐
HAVE YOU EVER EXPERIENCED GUM RECESSION?	☐	☐
IS THERE ANYONE WITH A HISTORY OF PERIODONTAL DISEASE IN YOUR FAMILY?	☐	☐
DO YOUR GUMS BLEED WHEN BRUSHING, FLOSSING, OR EATING?	☐	☐
ARE YOUR TEETH BECOMING LOOSE?	☐	☐
HAVE YOU EVER NOTICED AN UNPLEASANT TASTE OR ODOR IN YOUR MOUTH?	☐	☐
HAVE YOU EXPERIENCED A BURNING SENSATION IN YOUR MOUTH?	☐	☐

CONFIDENTIAL INFORMATION QUESTIONNAIRE

PATIENT'S NAME: LAST FIRST MIDDLE			DATE OF BIRTH:	SEX: M ☐ F ☐	SOCIAL SECURITY #:
PATIENT'S ADDRESS: STREET		CITY	STATE	ZIP	HOME PHONE:
MARITAL STATUS: M ☐ S ☐ D ☐ W ☐	UNDER 18 ☐	EMAIL ADDRESS:			CELL PHONE:
PATIENT / GUARDIAN'S EMPLOYER:				OCCUPATION:	
WORK ADDRESS: STREET		CITY	STATE	ZIP	WORK PHONE: / OK TO CALL? Y ☐ N ☐
SPOUSE'S NAME: LAST FIRST MIDDLE			SPOUSE'S EMPLOYER:		SPOUSE'S OCCUPATION:
SPOUSE'S ADDRESS: STREET		CITY	STATE	ZIP	SPOUSE'S PHONE:

PERSON WE CAN CONTACT INCASE OF EMERGENCY (OTHER THAN YOUR FAMILY HOME)

NAME: RELATIONSHIP: HOME #: WORK #: CELL #:

OTHER FAMILY MEMBERS WHO ARE PATIENTS HERE:	WHO CAN WE THANK FOR REFERRING YOU?

INSURANCE AND FINANCIAL INFORMATION

INSURANCE COVERAGE? YES ☐ NO ☐	INSURANCE COMPANY NAME:		
SUBSCRIBER'S NAME:	PATIENT'S RELATIONSHIP TO SUBSCRIBER: SELF ☐ SPOUSE ☐ DEPENDENT ☐	SUBSCRIBER'S DATE OF BIRTH:	SUBSCRIBER'S SSN:

ASSIGNMENT AND RELEASE:

I hereby authorize my insurance benefits to be paid directly to the dentists. I am financially responsible for any balance due and authorize the dentists to release any information for this claim. I authorize that my records can be used by the doctor if so determined.

In consideration of the serviced rendered to me by this dental office I am obligated to pay said office in accordance with its credit terms and policy.

I consent to the making of video tapes, photographs, and x-rays before, during, and after treatment, and to the use of same by the doctor in scientific papers or demonstrations.

I certify that I have read or had read to me the contents of this form and do realize the risks and limitations involved.

Patient Signature: _____ Date: _____

Doctor Signature: _____ Date: _____

JALINE BOCCUZZI, D.M.D., P.A.
2122 N.E. 2nd STREET
POMPANO BEACH, FL 33062
954-941-4310

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect ____/____/____, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

JALINE BOCCUZZI, D.M.D., P.A.
2122 N.E. 2nd STREET
POMPANO BEACH, FL 33062
954-941-4310

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

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

_____
Please Print Name

_____
Signature (Parent or Legal Guardian must also sign if the patient is under the age of 18.)

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

JALINE BOCCUZZI, D.M.D., P.A.
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Patient Name: _____ Date: _____

Reason for your visit: _____

Other than the services we have already provided for you, what additional services would you like to learn about? Please check all that apply.

- ☐ Injectable Treatments
- ☐ Juvéderm
- ☐ Botox
- ☐ Radiesse
- ☐ Facial Fine Lines / Wrinkles
- ☐ Thin Lips

Please answer the following questions on a scale of 1 to 5 circling the appropriate number:

When I look at my face in the mirror, I believe I look younger, the same age, or older than my true age.

Younger		True Age		Older
1	2	3	4	5

When I look in the mirror I am not concerned, somewhat concerned, or very concerned about the appearance of my wrinkles.

Not Concerned		Somewhat Concerned		Very Concerned
1	2	3	4	5