**Health Questionnaire**
**Scott E Schwartz D.D.S**
**1 Baltic Place**
**Croton, NY 10520**
**914-271-6224**

Date: _____

Name: _____ Social Security #: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Work: _____

Email Address: _____

Date of Birth: _____ Marital Status: _____

Physician's Name and Number: _____

Employer: _____ Occupation: _____

Name of Dental Insurance (if applicable): _____

If insurance coverage is through another person: Name of Subscriber: _____

Subscriber DOB: _____ Subscriber SSN: _____

Member ID#: _____ Group Number: _____

Referred By: _____

Have you received medical treatment during the past year Y or N. If yes for what? _____

_____

Have you had a skin reaction to jewelry? Y or N.

Anything you would like the doctor to be aware of?

How did you hear about our office?

Scott E. Schwartz, D.D.S
1 Baltic Place
Croton-on-Hudson, NY 10520
914-271-6224

What prompted you to seek dental care at this time? _____

Why did you leave your previous dental office? _____

Where may we request your x-rays from? _____

Town_____ Phone Number _____

Do you have regular dental visits? Yes or no How often? _____

When was your last thorough exam? _____

Are you happy with the appearance of your teeth? Yes or No If not, what would you like to change?

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| | | |
|---|---|---|
| Do you have any missing teeth? | Yes | No |
| Do you clench / grind your teeth? | Yes | No |
| Do you have any sensitivity in your teeth or gums? | Yes | No |
| Do your gums feel tender or swollen? | Yes | No |
| Do you floss your teeth? | Yes | No |
| Do your gums bleed? | Yes | No |
| Does food get caught in your teeth? | Yes | No |
| Do you avoid brushing or chewing in any parts of your mouth? | Yes | No |
| Has any dental treatment been suggested that you have not done? | Yes | No |

What concerns you most about dentistry? _____

_____

How do you feel in general about dentistry??

Love it It's ok I'm screaming on the inside Lock the door, I may run

Signature _____ Date _____

# Medical History

Name:_____

Any changes in address, phone number or insurance?_____

Email address:_____

Women: Are you pregnant? _____ Taking birth control pills? _____ Nursing? _____

PLEASE CIRCLE ANY OF THE OF THE FOLLOWING THAT YOU (YOUR CHILD) HAVE, HAD, OR NOW HAVE:

| | | |
|---|---|---|
| A-Fib | Cortisone Medication | High Blood Pressure |
| Aids/HIV Pos | Diabetes | Kidney Problems |
| Alcoholism | Drug Addictions | Liver Problems |
| Anemia | Emphysema | Mitral Valve Prolapse |
| Angina Pectoris | Epilepsy/Seizures | Pain in the jaw joints |
| Arthritis | Glaucoma | Rheumatic fever |
| Artificial Joints | Hay Fever | Sinus Trouble |
| Asthma | Heart Attack/ Disease/ Surgery (Murmur/ Pacemaker) | Thyroid Disease |
| Blood Transfusions | Hemophilia (bleeding problem) | Tuberculosis |
| Chemotherapy | Hepatitis A, B or C | Ulcers |
| Congenital Heart Defect | Venereal Diseases | |

Other: _____

ARE YOU ALLERGIC TO, OR HAVE YOU REACTED ADVERSELY TO ANY OF THE FOLLOWING :

| | | | |
|---|---|---|---|
| Aspirin | Latex | Nitrous Oxide | Tetracycline |
| Codeine | Local Anesthesia | Penicillin | |
| Erythomycin | Metals | Sedatives | |

Any other _____

Please List all Medications including Vitamins/Supplements:_____

_____

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Emergency Contact Name: _____ Phone Number: _____

To the best of my knowledge, all answers are correct. I will notify Dr. Schwartz if any changes in my health or medication should occur. I consent to necessary treatment being performed on me by Dr. Schwartz and his staff, and to the use of photos for education and commercial purposes. Also, I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include but are not limited to bruising, hematoma; cardiac stimulation; temporary or rarely, permanent numbness; or muscle soreness. I understand that occasionally needles may break and require surgical retrieval.

Sign:_____ Date: _____

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# 48 Hour Cancellation Policy

Our desire is to make all appointments as comfortable and convenient as possible. We understand sometimes a patient is unable to keep a scheduled appointment due to unforeseen circumstances. However, we require our patients notify the office at least 48 hours before the appointment needs to be cancelled or rescheduled. This allows us to offer the appointment to other patient's, if you fail to reschedule or cancel without notice there will be a $75 charge on your account.

Print name:_____

Sign:_____

Date: _____

HIPAA

Notice of Privacy Practices

Scott E. Schwartz, D.D.S

Print Patient Name: _____

Patient Birth Date:_____

We are required by law to maintain the privacy of and provide individuals with the attached notice of our legal duties and privacy practices with respect to protected health information. If you would like a copy of the notice, please ask the front desk.

I hereby acknowledge that I have been shown a copy of the HIPAA Notice of Privacy Practice.

_____ _____

Signature of patient or patient's representative/parent Date

_____

Printed name of patient's representative/parent

## PROVIDER USE ONLY

_____ Patient or patient representative refused to sign/accept Notice of Privacy Practices

_____ Patient unable to sign

_____

Signature Date/Time