DENTAL HEALTH INFORMATION

WHAT IS THE REASON FOR TODAY'S VISIT? _____

IF YOU ARE IN PAIN, DESCRIBE? _____

WHEN WAS YOUR LAST DENTAL VISIT? _____ WHAT WAS DONE AT THAT TIME? _____
DO YOU FEEL ANXIOUS OR APREHENSIVE? NOT AT ALL SOMEWHAT QUITE A BIT EXTREMELY

PREVIOUS DENTIST'S NAME_____PHONE _____
DID YOU MAKE REGULAR VISITS? **YES NO** HOW OFTEN? _____ DATE OF LAST DENTAL X-RAYS _____

ARE YOU FAMILIAR WITH THE TERM "*PREVENTIVE DENTISTRY*"? **YES NO**
HOW IMPORTANT ARE YOUR TEETH TO YOU? VERY SOMEWHAT INDIFFERENT NOT AT ALL
DO YOU BRUSH? **YES NO** FREQUENCY_____ DO YOU FLOSS? **YES NO** FREQUENCY _____
WHAT TYPE AND TEXTURE BRUSH DO YOU USE? SOFT_____MEDIUM_____HARD_____NYLON_____NATURAL____
DO USE MOUTHWASH? **YES NO** FREQUENCY _____ WHAT KIND? _____

DO YOUR GUMS IN GENERAL FEEL (CIRCLE): SORE TENDER PUFFY SWOLLEN? **YES NO**
DO YOUR GUMS BLEED WHEN BRUSHING? **YES NO** WHEN FLOSSING? **YES NO**
DO YOU FEEL YOUR BREATH IS OFFENSIVE AT TIMES? **YES NO** ARE YOU A MOUTH BREATHER? **YES NO**
HAVE YOU EVER HAD OR BEEN TOLD THAT YOU NEEDED PERIODONTAL (GUM) SURGERY? **YES NO**
DO YOU EXPERIENCE "DRY MOUTH"? **YES NO**

DOES FOOD GET CAUGHT BETWEEN YOUR TEETH? **YES NO** FOOD TYPE? _____ WHERE?_____
DO YOU HAVE TOOTH SENSITIVTY TO (CIRCLE): HOT COLD SWEETS BITING PRESSURE? WHERE**?** _____
DO YOU AVOID CHEWING IN ANY AREA OF YOUR MOUTH? **YES NO** WHERE? _____

HAVE YOU EVER WORN OR HAVE BEEN TOLD THAT YOU NEEDED ORTHODONTICS (BRACES)? **YES NO**
DO YOU CLENCH OR GRIND YOUR TEETH WHILE YOU ARE SLEEPING? **YES NO** WHILE AWAKE? **YES NO**
DOES YOUR JAW CLICK? **YES NO** DOES IT POP? **YES NO** DOES THIS CAUSE YOU DISCOMFORT? **YES NO**
DO YOU FREQUENTLY HAVE ACHES IN YOUR'E (CIRCLE): HEAD NECK SHOULDERS OR JAW? **YES NO**
DO YOU USE OR HAVE YOU EVER BEEN TOLD TO USE A NIGHT GUARD? **YES NO**
HAVE YOU EVER HAD SEVERE TRAUMA TO YOUR HEAD, NECK OR JAW? **YES NO** IF SO, EXPLAIN _____

_____

HAVE YOU LOST ANY TEETH? **YES NO** HAVE THEY BEEN REPLACED? **YES NO**
IF SO, HAVE THEY BEEN REPLACED WITH A (PLEASE CHECK ALL THAT APPLY) FIXED BRIDGE _____
REMOVABLE BRIDGE _____ COMPLETE DENTURE _____ IMPLANTS _____?
ARE YOU PLEASED WITH THE REPLACEMENT? **YES NO**
WOULD YOU LIKE TO KNOW ABOUT ALTERNATIVE REPLACEMENTS IF INDICATED? **YES NO**

DO YOU HAVE ANY CHIPPED, SHIFTED, BROKEN OR DISCOLORED TEETH? **YES NO**
DOES THE APPEARANCE OF YOUR TEETH AND SMILE: PLEASE YOU BOTHER YOU NO OPINION?
WOULD YOU LIKE TO KNOW ABOUT VARIOUS COSMETIC DENTAL PROCEDURES SUCH AS BLEACHING, BONDING, TOOTH RECONTOURING OR PORCELAIN VENEERS? **YES NO**

HAVE YOU EVER HAD ANY PROBLEMS, COMPLICATIONS, UNPLEASANT EXPERIENCES WITH PREVIOUS DENTAL TREATMENT OR DO YOUHAVE ANY QUESTIONS, CONCERNS OR ANYTHING ELSE YOU FEEL WE SHOULD KNOW OR WOULD LIKE TO DISCUSS? **YES NO** IF YES, EXPLAIN_____

_____

_____

_____

_____

TO THE BEST OF MY KNOWLEDGE, ALL OF THE PROCEDING ANSWERS AND INFORMATION PROVIDED ARE TRUE AND CORRECT. IF I EVER HAVE ANY CHANGE IN MY HEALTH I WILL INFORM DR. PUGLISI'S OFFICE AS SOON AS POSSIBLE AND CERTAINLY NO LATER THAN MY NEXT APPOINTMENT <u>WITHOUT FAIL</u>.
I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL FEES FOR DENTAL TREATMENT PROVIDED

SIGNATURE OF PATIENT, PARENT OR GUARDIAN _____ DATE _____
Medical and Dental History: Directly reviewed with the patient, parent or guardian. DR. _____
Rev.5/15

CHARLES E. PUGLISI, D.M.D.
39 FIFTH AVENUE NY, NY 10003 212-529-2929

To help us render proper dental care, please answer the following questions.
Your **complete** answers are vital for us to provide proper treatment and avoid possible adverse treatment results.
Circle the appropriate answer or provide the information requested. Your answers are for our records only and will be considered confidential. You will have the opportunity to speak ***privately*** with Dr. Puglisi.

PATIENT INFORMATION

NAME_____ M / F TODAYS DATE _____
Last First Mi Gender
BIRTHDATE _____SOCIAL SECURITY#_____ MARITAL STATUS _____

ADDRESS _____
Apt # City State Zip
PHONE #'S _____ _____ _____
Home Business Ext. Mobile

_____ _____ **E-MAIL ADDRESS** _____
Fax Best Time To Call
OCCUPATION _____ WOULD YOU PREFER TO BE ADDRESSED BY YOUR FIRST OR LAST NAME?

EMERGENCY CONTACT _____ PHONE_____

WHOM MAY WE THANK FOR YOUR REFERRAL? _____
PREFERRED APPOINTMENT TIMES? MORNING AFTERNOON EVENING DAY OF WEEK _____

MEDICAL HEALTH INFORMATION

ARE YOU IN GOOD HEALTH? **YES NO** ARE YOU CURRENTLY UNDER THE CARE OF A PHYSICIAN? **YES NO**
PHYSICIAN'S NAME _____ PHONE _____ LAST PHYSICAL EXAM DATE? _____

HAVE YOU HAD A SERIOUS ILLNESS, OPERATION OR HAVE BEEN HOSPITALIZED IN THE LAST FIVE YEARS?
YES NO IF SO, EXPLAIN _____

DO YOU REQUIRE PREMEDICATION WITH ANTIBIOTICS FOR DENTAL OR MEDICAL PROCEDURES? **YES NO**
ARE YOU ALLERGIC TO: PENICILLIN **YES NO**, LATEX **YES NO**, ANY OTHER ANTIBIOTICS, ANESTHETICS, DRUGS, FOODS OR HAVE ANY OTHER ALLERGIES? **YES NO** LIST _____
DO YOU TAKE BIRTH CONTROL PILLS? **YES NO**, ANY OTHER HORMONE TYPE MEDICATIONS? **YES NO**
ARE YOU OR THINK YOU MIGHT BE PREGNANT? **YES NO** ARE YOU NURSING? **YES NO**
HAVE YOU EVER TAKEN THE WEIGHT LOSS MEDICATION PHEN-PHEN? **YES NO**
HAVE YOU EVER TAKEN BISPHOSPHONATES SUCH AS: ACTONEL, ZOMETA, FOSAMAX OR BONIVA? **YES NO**
DO YOU TAKE ANY PRESCRIBED, NON- PRESCRIBED, OVER THE COUNTER MEDICATIONS (INCLUDING ASPIRIN), DIETARY SUPPLEMENTS OR NATURAL REMEDIES? **YES NO**, IF SO LIST_____

DO YOU HAVE OR HAVE YOU EVER HAD OR BEEN TREATED FOR THE FOLLOWING PROBLEMS OR DESEASES?

CARDIAC PROBLEMS (ANGINA, HEART ATTACK)	**YES NO**	FAINTING, EPILEPSY, OR SEIZURES	**YES NO**
PACEMAKER	**YES NO**	NEUROLOGICAL DISORDERS	**YES NO**
CONGENITAL HEART LESIONS	**YES NO**	STROKE, TIA, HARDENING OF ARTERIES	**YES NO**
RHEUMATIC FEVER	**YES NO**	PROBLEMS WITH MENTAL HEALTH	**YES NO**
HEART VALVE DEFECTS OR REPLACEMENT	**YES NO**	LIVER PROBLEMS, JAUNDICE, HEPATITIS	**YES NO**
MITRAL VALVE PROLAPSE	**YES NO**	ANEMIA OR OTHER BLOOD PROBLEMS	**YES NO**
HEART MURMER	**YES NO**	EXCESSSIVE BLEEDING, BRUISE EASILY	**YES NO**
HIGH OR LOW BLOOD PRESSURE	**YES NO**	BLOOD TRANSFUSIONS	**YES NO**
STOMACH PROBLEMS, ULCERS	**YES NO**	SEXUALLY TRANSMITTED DISEASE	**YES NO**
ESOPHAGEAL HERNIA OR GASTRIC REFLUX	**YES NO**	TUMORS OR CANCER	**YES NO**
DIFFICULTY SWALLOWING, VOMITING/ NAUSEA	**YES NO**	RADIATIATON TREATMENTS	**YES NO**
ASTHMA, TB, EMPHYSEMA, LUNG DISEASE	**YES NO**	CHEMOTHERAPY	**YES NO**
PERSISTENT COUGH, COUGH UP BLOOD	**YES NO**	PROBLEMS WITH IMMUNE SYSTEM	**YES NO**
DIARRHEA, CONSTIPATION, BLOOD IN STOOL	**YES NO**	PERSISTENT SWOLLEN GLANDS	**YES NO**
DIABETES	**YES NO**	AIDS OR HIV	**YES NO**
EXCESSIVE URINATION OR THURST	**YES NO**	ARTHRITIS, RHEUMATISM	**YES NO**
FAMILY HISTORY: DIABETES, HEART DESEASE	**YES NO**	ARTIFICIAL JOINTS/ PROSTHESIS	**YES NO**
SHORTNESS OF BREATH, SWOLLEN ANKLES	**YES NO**	BREAST, FACIAL, IMPLANTS	**YES NO**
SINUS PROBLEMS/ DESEASE, HAY FEVER	**YES NO**	EYE DISEASE, GLAUCOMA	**YES NO**
KIDNEY, BLADDER PROBLEMS/ DISEASE	**YES NO**	HEARING PROBLEMS, RINGING IN EARS	**YES NO**
THYROID, ADRENAL PROBLEMS/ DISEASE	**YES NO**	EATING DISORDERS	**YES NO**
DO YOU SMOKE OR CHEW TOBACCO	**YES NO**	SLEEP APNEA/ DAYTIME SLEEPINESS	**YES NO**
DO YOU CONSUME ALCOHOL	**YES NO**	ALCOHOL OR DRUG DEPENDANCE	**YES NO**
DO YOU USE RECREATIONAL DRUGS	**YES NO**	DO YOU WEAR CONTACT LENSES	**YES NO**

Evaluation: CEP ____

Patient Screening Form

Patient Name:

	PRE-APPOINTMENT	IN-OFFICE
	Date:	Date:
Do you/they have fever or have you/they felt hot or feverish recently (14-21 days)?	☐ Yes ☐ No	☐ Yes ☐ No
Are you/they having shortness of breath or other difficulties breathing?	☐ Yes ☐ No	☐ Yes ☐ No
Do you/they have a cough?	☐ Yes ☐ No	☐ Yes ☐ No
Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	☐ Yes ☐ No	☐ Yes ☐ No
Have you/they experienced recent loss of taste or smell?	☐ Yes ☐ No	☐ Yes ☐ No
Are you/they in contact with any confirmed COVID-19 positive patients? *Patients who are well but who have a sick family member at home with COVID-19 should consider postponing elective treatment.*	☐ Yes ☐ No	☐ Yes ☐ No
Is your/their age over 60?	☐ Yes ☐ No	☐ Yes ☐ No
Do you/they have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	☐ Yes ☐ No	☐ Yes ☐ No
Have you/they traveled in the past 14 days to any regions affected by COVID-19? (as relevant to your location)	☐ Yes ☐ No	☐ Yes ☐ No

Positive responses to any of these would likely indicate a deeper discussion with the dentist before proceeding with elective dental treatment.

- For testing, see the list of State and Territorial Health Department Websites for your specific area's information.

Charles E. Puglisi, DMD., F.A.G.D.
39 Fifth Avenue.
New York, NY 10003

Notice of Privacy Practices

HIPPA Privacy Form 1

Purpose: This form, Notice of Privacy Practices, presents the information that federal law requires us to give our patients regarding our privacy practices.

We must provide this Notice to each patient beginning no later than the date of our first service delivery to the patient, including service delivered electronically.

We must make a good-faith attempt to obtain written acknowledgement of receipt of the Notice from the patient. We must also have the Notice available at the office for patients to request to take with them.

We must post the Notice in our office in a clear and prominent location where it is reasonable to expect any patients seeking service from us to be able to read the Notice.

Whenever the Notice is revised, we must make the Notice available upon request on or after the effective date of the revision in a manner consistent with the above instructions.

Thereafter, we must distribute the Notice to each new patient at the time of service delivery and to any person requesting a Notice.

We must also post the revised Notice in our office as discussed above.

Charles E. Puglisi, DMD., F.A.G.D.
39 Fifth Avenue.
New York, NY 10003

Acknowledgement of Recipt of Notice of Privacy Practices

You may refuse to sign this form if you wish.

I,_____ ,

(Please Print Name)

have received a copy of this office's Notice of Privacy Practices. I have read it thoroughly and underatand its contents.

X _____

(Signature)

_____/_____/_____

(Date)

For Office Use Only

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)_____

THE GREENWICH VILLAGE DENTIST

Charles E. Puglisi, DMD., F.A.G.D.
39 Fifth Avenue.
New York, NY 10003

Pre-authorization Payment Form

Please complete before your first visit and update payment information as it changes.

Dear Patient:

In an effort to provide you with quality dental care and flexible payment arrangements, we have expanded our payment policy. Payment arrangements are requested by the time of your first visit. We now offer the following payment options:

- Payment by cash
- Automatic monthly billing to your Credit Card or Debit Card
- Guarantee your insurance co-payments with Credit Card or Debit Card

Credit Card Information

Please complete information below and return to our office before your visit.

Name on Card: _____

Card Type: VISA | MASTERCARD | DISCOVER | AMERICAN EXPRESS

Account Number: _____-_____-_____-_____

Exp. Date _____/_____ Security Code _____ Billing Zip code _____

Cardholder Signature _____

Date: _____/_____/_____

For Our Patients Using VISA/MASTERCARD:
Our office is a fully approved and accredited user of the VISA/MASTERCARD Health Care Incentive Program which will enable you to use your VISA/MASTERCARD to automatically cover amounts not paid by your insurance.

For Our Patients Using Delta Dental Insurance:

- We will submit your dental claim electronically on the same day of your treatment visit.
- Delta Dental will forward payment directly to you not Dr. Puglisi or our office.
- It may take up to 3 weeks for reimbursement, so please contact us as soon as you have received payment from Delta Dental.
- We will automatically charge your credit card for your treatment after 30 days if you have not notified us.