Strom, Klein & Harkavy associates

Special Needs ● Cosmetic ● Same Day Dentist®

Welcome to our Practice!

It is our goal at Strom, Klein & Harkavy Associates to provide you with the most comprehensive care possible. Please take a minute and fill out this thorough medical history form.

General Information

Name: ______________________________ Date: __________

I prefer to be called: ______________________ Male Female

DOB: __________ Age: ____ SS#: ______________ Email: ___________________________

Home Address: ____

City_____________________________State______________Zip____________

Mobile Phone #_______________________ Alternate Phone #____________________________

Employer_____________________ Who can we thank for referring you to us?_____________________

Preferred contact method (circle all that apply): Phone Call Text Email Postcard

Emergency Contact:

Name: ____________________ Relation: ________________ Phone: ________________

Dental Insurance Information:

Primary Dental Insurance: _________________________ Phone Number: ____________________

Insurance Company Address: ____

Insured's Name: ______________________ Relation: ____________________

Group #: ___________________________ Insured's Birthdate: ______________

Insured's SS# / ID#: ____________________ Insured's Employer: ______________

Secondary Dental Insurance: _______________________ Phone Number: ____________________

Insurance Company Address: ____

Insured's Name: ______________________ Relation: ____________________

Group #: ___________________________ Insured's Birthdate: ______________

Insured's SS# / ID#: ____________________ Insured's Employer: ______________

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Medical History Please circle the appropriate answer (Leave blank if you do not understand the question)

Yes / No Is your general health good?
If NO, please explain: ____________________

Yes / No Has there been a change in your health in the last year?
If YES, please explain: ____________________

Yes / No Have you gone to the Hospital, Emergency Room, or had a serious illness in the last three (3) years?
If YES, please explain: ____________________

Yes / No Are you currently being treated by a physician?
If YES, please explain: ____________________

Date of last medical exam: ____________________
Name of Physician: ____________________
Phone number of physician: ____________________

Yes / No Are you taking any kind of medication? (including prescription & supplements)

Please list (legibly):

____

____

Dental History

When was your last dental visit? ____________________

What is the primary reason for your visit today? ____________________

Are you interested in (check all that apply):

___Whitening ___Straightening your teeth ___Sedation

___Sleep apnea treatment ___Veneers ___Same day crowns

Yes / No Have you had any problems with dental treatment in the past?
If YES, please explain: ____________________

Yes / No Are you in pain now?
If YES, please explain: ____________________

Yes / No Do you have dental anxiety?
If YES, please rate your level of anxiety (circle one):
Very High High Medium Low

What makes you most anxious? ____________________

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Cardiovascular Health

Do you have/had:

Y N … Angina
Y N … Chest pain when lying down
Y N … Chest pain during physical exertion
Y N … Congenital Heart disease
Y N … Damaged/Artificial heart valves
Y N … Difficulty breathing when lying down
Y N … Congenital Heart disease
Y N … Heart attack
Y N … Heart Murmur/rheumatic heart disease
Y N … Heart Surgery(please specify)
Y N … High Blood Pressure
Y N … Pacemaker
Y N … Swollen ankles

Respiratory Health

Do you have/had:

Y N … Asthma
Y N … Bronchitis
Y N … Coughed up blood
Y N … Emphysema
Y N … Persistent cough for > 3 months
Y N … Pneumonia
Y N … Sinus problems
Y N … Tuberculosis

Neuromuscular

Do you have/had:

Y N …Fainting spells/dizziness
Y N …Numbness/tingling/paralysis
Y N …Muscle weakness/Multiple Sclerosis
Y N … Painful joints/Arthritis
Y N … Problems with walking/balance
Y N … Recurrent/chronic back/neck aches
Y N … Recurrent migraine headaches
Y N … Seizures/epilepsy

GI/GU

Do you have/had:

Y N …Acid Reflux/Heartburn
Y N …Blood in stool/urine
Y N …Chron's/Colitis
Y N …Difficulty swallowing
Y N …Excessive thirst
Y N …Frequent urination
Y N …Frequent vomiting
Y N …Hepatitis
Y N …Kidney disease/dialysis/transplant
Y N …Liver disease

Hematology/Endocrine/Immune

Do you have/had:

Y N …Anemia
Y N …Auto-immune Disorder:
Y N …Cancer/tumor
Did you receive chemotherapy and or radiation?____________________
Y N …Canker sore/Cold sore
Y N …Diabetes
Y N …Hemophilia
Y N …HIV/AIDS
Y N …Lymphoma/Leukemia/Bone marrow transplant
Y N …Persistent swollen lymph glands in the neck
Y N …Prolonged bleeding (>10 minutes) / Easy bruising
Y N …Received a Blood Transfusion
Y N …Rheumatoid Arthritis
Y N …Sexually Transmitted Disease
Y N …Thyroid problems

Social/Psych

Have you been treated for any of the following:

Y N …Alcohol Use
Y N …Attention Deficit/Hyperactivity Disorder
Y N …Autism
Y N …Bipolar/Schizophrenia
Y N …Depression
Y N …Anxiety
Y N …Intravenous Drug Use
Y N …Panic Attacks
Y N …Recreational Drug Use
Y N …Tobacco use

Allergies

Y N …Aspirin
Y N …Barbituates, Sedatives, or sleeping pills
Y N …Codeine
Y N …Latex
Y N …Local/dental anesthetics
Y N …Penicillin or Other Antibiotics
Y N …Sulfa drugs
Y N …Other Drugs: ________________________

Skeletal

Do you have/had:

Y N …Bone infections
Y N …Metal screws/artificial implants
Y N …Osteoporosis
Y N …Total/Partial joint replacement
Y N …Taken any Oral, Intravenous Bisphosphonates or other medications for your bones (ex. Fosamax, Boniva, Zometa, Aredia, Prolia, Actonel, Forteo)

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Females Only:

Y N ...Are you pregnant or trying to get pregnant
If yes, when are you due?______________________________
Y N ...Are you nursing
Y N ...Are you taking Birth Control
Y N ...Hormone Therapy
Y N ...Menopause

Sleep Apnea

Y N ...Do you snore or have you ever been told that you snore?
Y N ...Have you ever been told you stop breathing while asleep?
Y N ...Have you been diagnosed with sleep apnea?
Y N ...Are you currently using a CPAP machine?
If yes, would you prefer an oral appliance?__________________

Do you have any other medical conditions that are not listed on this form? Additionally, if you answered YES to any of the above questions, please elaborate:
____
____
____
____
____

I have read and understood the above questionnaire and have answered all questions truthfully to the best of my ability. I also understand that this information will be held in the strictest of confidence and is my responsibility to inform this office of any changes to my medical status.

____ ______________
(Patient Signature) (Date)

Doctor's Notes:

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FINANCIAL AGREEMENT

Welcome to our practice! Our goal is to help you make the best treatment choices for your dental needs and understand your financial responsibility, before treatment begins

If you have dental insurance, our business staff can help you complete your insurance forms and *estimate* the coverage of your particular plan. However, our dental office cannot render services solely on the assumption that your insurance company will pay that estimated amount. Please be aware that some, or perhaps all, of the services provided may or may not be covered by your insurance policy. Any remaining balance is your responsibility.

Our patients who have dental insurance are expected to pay the amount of their *estimated* co-pay and deductible at the time of service. If there are any questions or concerns about that, please talk to our staff so we can do our best to accommodate you.

I authorize release of any information about my healthcare to the insurance company for the sole purpose of administering insurance claims and benefits and payment of insurance benefits directly to the office. I understand that my insurance contract is between me and my insurance company and not the dental office.

If, for any reason, this account is assigned for collection, I agree to pay the overdue amount, cost of collection (50% of total) plus reasonable attorney fees.

CANCELLATION OF AN APPOINTMENT WITH A DOCTOR

Out of respect to our other patient's needs, please call our office promptly if you cannot keep your appointment so we can try to give that time to another patient. For cancellations less than 2 business days in advance there will be a charge up to 30% of the planned treatment.

CANCELLATION OF A HYGIENE APPOINTMENT

We want you to keep your recommended hygiene schedule in order to best maintain good oral health.
If, for any reason, you are unable to keep your scheduled hygiene appointment, please contact us as soon as possible. Any appointment not cancelled or rescheduled 2 business days in advance is subject to a charge of the full treatment total.

I hereby acknowledge that I have read, understand, and agree to adhere to the practice's policies as outlined above.

Name of Patient____

Signature of guarantor of payment/responsible party________________________

Relationship to Patient (if not self)______________________________

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HIPAA Acknowledgement

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. THESE RIGHTS ARE GIVEN TO ME UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA).

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

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 is in effect and will remain so 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 sue 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 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 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 our 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 persons 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 your 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.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards or letters).

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PATIENT RIGHTS:
Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable cost based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.
Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail(e-mail), you are entitled to receive this Notice in written form.

Telephone: 310/277-3451
Fax: 310/277-4136

Address: 350 S Beverly Drive #180, Beverly Hills, CA 90212

Name of Patient______________________________ Date_______________

Signature of Guarantor/Responsible Party __________________________ Date _______________

Relationship to Patient (if not self)____________________________________