THE STEIN CENTER FOR ADVANCED DENTISTRY

ABRAHAM E. STEIN, D.M.D., M.S.

4711 Golf Road Suite 912 Skokie, Illinois 60076 (847) 676-3500 Fax (847) 676-3090

HEALTH QUESTIONNAIRE

Date _____

Name _____ (First / Middle / Last)

Date of Birth _____

Address _____ **City** _____ **Zip Code** _____

Home Phone # _____ **Cell #** _____ **Business Phone #** _____

Occupation _____ **Employer** _____ **Business Address** _____

Marital Status _____ **Spouse Name** _____

In Case of Emergency, notify _____ **Phone #** _____

E-Mail Address _____ **Cell #** _____

DENTAL INSURANCE INFORMATION (Primary Carrier)

Insured's Name _____

Insurance Co. _____

Insurance Co. Address _____

Insured's Employer _____

Insured's Soc. Sec. # _____ Group # _____ Local # _____

If you have double insurance coverage, complete this for the second coverage.

Insured's Name _____

Insurance Co. _____

Insurance Co. Address _____

Insured's Employer _____

Insured's Soc. Sec. # _____ Group # _____ Local # _____

Who can we thank for referring you to our office? _____

Do you have or have you had any of the following diseases or problems: Please check yes or no. Your answers are for our records only and will be considered confidential;

	YES	NO
Heart Disease or Attack		
Heart Surgery, Stent Placement		
Angina		
High Blood Pressure		
Low Blood Pressure		
Heart Murmur		
Rheumatic Fever		
Congenital Heart Lesions		
Mitral Valve Prolapse		
Artificial Heart Valve		
Pacemaker		
Stroke		
Artificial Joints (Hip, Knee etc)		
Anemia		
Hemophilia (Bleeding Problems)		
Kidney Disease		
Stomach Ulcers		
A.I.D.S./A.R.C./HIV Pos.		
Osteoporosis/Osteopenia		

	YES	NO
Hepatitis A (Infectious) or B (Serum)		
Hepatitis C or Delta Hepatitis		
Liver Disease		
Blood Transfusions		
Diabetes		
Thyroid Diseases		
Tuberculosis		
Asthma		
Hay Fever		
Sinusitis		
Epilepsy or Seizures		
Venereal Disease (Herpes etc)		
Cancer		
Chemotherapy or Radiation Treatment		
Chemical, Alcohol Dependency		
Allergies		
Arthritis		
Other:		

Is there anything else we should know about your medical history? _____

Are you currently under care of a physician - please explain: _____

Have you ever had any surgery? _____

Have you been in the hospital within the past 5 years? _____

Do you have any bleeding problems? _____

Have you ever been informed of the need to take antibiotics for dental treatment? If so, what antibiotic? _____

The name, phone number and address of my physician is: _____

_____

Have you ever responded adversely to medical or dental treatment? _____

Do you suspect that you are pregnant? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No How much?

11. Are you taking any drug or medicine such as any of the following					
a. Antibiotics or sulfa drugs	YES	NO	g. Aspirin	YES	NO
b. Anticoagulants (blood thinners)	YES	NO	h. Insulin, tolbutamide (Orinase) or similar drug	YES	NO
c. Medicine for high blood pressure	YES	NO	i. Digitalis or drugs for heart trouble	YES	NO
d. Cortisone (steroids)	YES	NO	j. Nitroglycerin	YES	NO
e. Tranquilizers	YES	NO	k. Bisphosphonates (Fosamax, Boniva, Zometa, etc.)	YES	NO
f. Antihistamines	YES	NO	l. Other	YES	NO

Please List Medications (prescription, over-the-counter or natural/herbal): _____

_____

Are you allergic or have you reacted adversely to: Please circle

Local Anesthetics
Aspirin
Latex
Iodine
Metals
Penicillin
Sulfa
Erythromycin
Codeine
Nitrous Oxide
Other _____

DENTAL HISTORY

		YES	NO
1. When was your last dental exam?	Date:		
2. When was your last full mouth X-ray taken?	Where?		
3. Are you fearful of dental procedures?			
4. Do you have pain in your jaw or near your ears, headaches?			
5. Do you have any unhealed injuries or inflamed areas in or around your mouth?			
6. Have you experienced any growths or sore spots in your mouth?			
7. Do you habitually clench or grind your teeth during the night or day?			
8. Is any part of your mouth sensitive to pressures or irritants (hot, cold, or sweets)?			
9. Have you ever had a bad reaction to local anesthetics?			
10. Have you ever had any difficult extractions in the past?			
11. Have you ever had prolonged bleeding following extractions in the past?			
12. Do your gums bleed?			
13. Do you have a bad taste in your mouth, or mouth odor?			
14. Have you ever had instructions on the care of your gums?			
15. Is there anything about your dental appearance that concerns you?	Shade of Teeth? Smile?		
16. Is there anything else we should know about how to treat you as a dental patient that we have not asked?			

Signature: _____ Date: _____

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

MEDICAL HISTORY UPDATES

DATE	SIGNATURE	DATE	SIGNATURE

The Stein Center for Advanced Dentistry

NOTICE OF PRIVACY PRACTICES & PATIENT CONSENT
FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT NAME (print) _____ DATE _____

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain Patient Rights regarding my protected health information.

I understand that Abraham Stein, DMD, MS, P.C. dba The Stein Center for Advanced Dentistry may use or disclose my protected health information for treatment, payment or healthcare operations, which means for providing healthcare to me, the patient; handling billing and payment; and taking care of other healthcare operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

The Practice has a detailed document call the **"Notice of Privacy Practices"**. It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

I understand that I have the right to read the **"Notice"** before signing this agreement. If I ask, The Stein Center for Advanced Dentistry will provide me with the most current **Notice of Privacy Practices.**

My signature below indicates that I have been given the chance to review such copy of the **Notice of Privacy Practices.** My signature means that I agree to allow The Stein Center for Advanced Dentistry to use and disclose my protected health information to carry out treatment, payment, and healthcare operations. I have the right to revoke this consent in writing at any time, except to the extent that The Stein Center for Advanced Dentistry has taken action relying on this consent.

SIGNATURE (Patient or Legal Custodian/ Authorized Representative) _____ **DATE** _____

Relationship to Patient (If Signed by Custodian/Representative) _____ **DATE** _____

You may obtain a copy of our **Notice of Privacy Practices,** including any revisions of our "Notice" at any time by contacting:

The Stein Center for Advanced Dentistry
4711 Golf Road, Suite 912
Skokie, IL 60076
Phone: (847) 676-3500