Medical History

Dale Petrusha DDS, PC
Creating beautiful, healthy smiles for a lifetime

Patient's Name _____

Name of Physician _____ Phone Number:_____

Date/purpose of last visit _____

What is your estimate of your general health? □ Excellent □ Good □ Fair □ Poor

Have you ever been hospitalized or had a major operation? □ Yes □ No If yes, please explain: _____

Have you ever had a serious head or neck injury? □ Yes □ No If yes, please explain: _____

_____

Are you on a special diet? □ Yes □ No

Do you or have you ever used tobacco? □ Yes □ No Do you use controlled substances? □ Yes □ No

Are you currently taking any medications, pills, or drugs? □ Yes □ No If yes, please explain: _____

_____

Women: Are you
Pregnant/Trying to get pregnant? □ Yes □ No Taking oral contraceptives? □ Yes □ No Nursing? □ Yes □ No

Are you allergic to any of the following?
□ Aspirin □ Penicillin □ Codeine □ Acrylic □ Latex □ Local Anesthetics □ Erythromycin □ Tetracycline □ Fluoride
□ Metals (Gold, Stainless steel) □ Other If yes, please explain:_____

Have you (or your dependent child) ever had any of the following?

AIDS/HIV Positive	□ Yes □ No	Difficulty Swallowing	□ Yes □ No	Low blood pressure	□ Yes □ No
Alcohol/Drug Dependency	□ Yes □ No	Emphysema	□ Yes □ No	Lung disease	□ Yes □ No
Alzheimer's Disease	□ Yes □ No	Epilepsy/convulsions (seizures)	□ Yes □ No	Mitral valve prolapse	□ Yes □ No
Anemia or other blood disorder	□ Yes □ No	Excessive thirst	□ Yes □ No	Night sweats	□ Yes □ No
Angina	□ Yes □ No	Frequent headaches	□ Yes □ No	Osteoporosis/osteopenia	□ Yes □ No
Any lumps or swelling in the mouth	□ Yes □ No	Glaucoma	□ Yes □ No	(taking bisphosphonates)	
		Hay fever	□ Yes □ No	Prolonged bleeding due to a slight cut	□ Yes □ No
Artificial heart valve	□ Yes □ No	Heart Attack/failure	□ Yes □ No	Radiation treatment	□ Yes □ No
Artificial joint	□ Yes □ No	Heart problems/disease	□ Yes □ No	Renal dialysis	□ Yes □ No
Arthritis	□ Yes □ No	Heart murmur	□ Yes □ No	Rheumatic fever	□ Yes □ No
Bleeding disorder	□ Yes □ No	Heart pacemaker	□ Yes □ No	Rheumatism	□ Yes □ No
Blood transfusion	□ Yes □ No	Hemophilia	□ Yes □ No	Scarlet fever	□ Yes □ No
Breathing or sleeping problems (i.e.snoring, sinus, sleep apnea)	□ Yes □ No	Hepatitis (Type_____)	□ Yes □ No	Sickle Cell Disease	□ Yes □ No
		High Blood pressure	□ Yes □ No	Sinus trouble	□ Yes □ No
Cancer	□ Yes □ No	High cholesterol	□ Yes □ No	Stroke	□ Yes □ No
Chemotherapy	□ Yes □ No	Hives, rash, hay fever	□ Yes □ No	Thyroid or parathyroid disease	□ Yes □ No
Chest pains	□ Yes □ No	HPV(Human Papilioma Virus)	□ Yes □ No	Tonsillitis	□ Yes □ No
Cold sores/Fever blisters	□ Yes □ No	Hypoglycemia	□ Yes □ No	Tuberculosis	□ Yes □ No
Congenital heart disorder	□ Yes □ No	Intestinal or stomach disorder	□ Yes □ No	Tumor, abnormal growth	□ Yes □ No
Cortisone medication	□ Yes □ No	Kidney disease	□ Yes □ No	Ulcers	□ Yes □ No
Diabetes	□ Yes □ No	Leukemia	□ Yes □ No		
Digestive Disorders (i.e. gastric reflux)	□ Yes □ No	Liver disease	□ Yes □ No		

Please list any serious illness not listed above, current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment. _____

_____

Authority To Proceed

I certify that the answers given to the preceding questions are correct to the best of my knowledge. I hereby grant authority to Dr. Dale Petrusha to administer any treatment, to administer such anesthetics, and to perform such procedures as my be deemed necessary in the diagnosis and treatment of my case. I acknowledge that I will be informed of the risks and possible consequences of the treatment proposed and do authorize Dr. Dale Petrusha to proceed.

Signature_____ Date_____

Patient Responsibility Notice Waiver Form

Dr. Dale Petrusha provides many different types of dental services including exams, emergency treatment, fillings, crowns, extractions, root canals, periodontal treatment and all forms of general dentistry. Although most insurance companies cover a percentage of most services, there are some insurance companies that do not cover certain types of procedures.

Our staff makes every effort to assist you in understanding your dental health benefits. However, it is impossible for us to know all the many different employer group benefits from one employer to the next. Therefore, we are providing this Notice to inform you of the following responsibilities as they relate to benefit coverage and payment responsibilities by the patient and Dr. Dale Petrusha.

Dr. Petrusha's Responsibilities:

Dr. Petrusha is not responsible for knowing what services are covered by the patient's insurance plan and is not responsible for informing the patient whether a particular service is covered.

Dr. Petrusha will assist the patient in obtaining payment from his/her insurance company by submitting the necessary insurance claims.

Patient's Responsibilities:

It is the patient's responsibility to know and understand his/her own dental insurance benefit coverage and limits. The patient is ultimately responsible for payment for all services rendered by Dr. Petrusha at the time of treatment, and the patient must pay for any services not covered by the patient's insurance company.

By signing below, I hereby acknowledge and understand my responsibilities as a patient of Dr. Petrusha and accept that Dr. Petrusha is not responsible for knowing my dental insurance benefits for services provided.

Consent for use and disclosure of health information

Section B: To the patient—Please read the following statements carefully.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practice: You have the right to read our Notice of Privacy Practice before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by using the following contact information:

Contact Person: Dr. Dale Petrusha, DDS **Address:** 25908 Ford Road Dearborn Heights, MI 48127
Telephone: 313-277-0050 **Fax:** 313-277-4183

Right to Revoke: You will have the right to revoke the consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of the Consent will not effect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I, _____, have had full opportunity to read and consider the contents of the Consent form and your Notice of Privacy Practice. I understand that by signing the Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

Signature:_____ Date:_____