CONFIDENTIAL MEDICAL HISTORY

PAUL C. KATZ, D.D.S.
NATHALIE SELVANATHAN, D.D.S.

1. Has there been any change in your general health in the last two years? Yes ☐ No ☐
2. Approximate date of last physical exam ____________
3. Are you now under the care of a Physician? Yes ☐ No ☐
   If yes, for what : ____________
4. Have you had any serious illness, operation or hospitalization within the last 5 years? Yes ☐ No ☐
   Please describe: ____________
5. Are you taking any medication? Yes ☐ No ☐
   Please list : ____________
6. Are you taking any of the following:

	Yes	No		Yes	No
Anticoagulants (Blood Thinners)	☐	☐	Tranquilizers	☐	☐
Blood Pressure Medication	☐	☐	Insulin	☐	☐
Cortisone (Steroids)	☐	☐	Heart Drugs, Nitroglycerin	☐	☐

7. Are you allergic, or have you reacted adversely to any medication or foods? Yes ☐ No ☐
8. Have you had a bad reaction to :

	Yes	No
Latex	☐	☐
Local Anesthetics (Novocaine, Lidocaine)	☐	☐
Penicillin or other Antibiotics	☐	☐
Barbiturates, Sedatives, Sleeping Medicines.	☐	☐
Aspirin or Codeine	☐	☐

9. Have you taken medication for osteoporosis such as Fosamax (alendronate), Actoonel (risedronate), Boniva (ibandronate) or others? Yes ☐ No ☐

HAVE YOU HAD ANY OF THE FOLLOWING?

	Yes	No		Yes	No
Chronic sinus problems	☐	☐	Jaw joint pain or noises	☐	☐
Asthma, emphysema, bronchitis.	☐	☐	Kidney disease or stones	☐	☐
Frequent hives or skin rash	☐	☐	Tuberculosis	☐	☐
Current contagious diseases	☐	☐	Venereal disease	☐	☐
Rheumatic fever, heart murmur	☐	☐	Abnormal bleeding after surgery.	☐	☐
Congenital heart disease	☐	☐	Hemophilia, anemia, sickle cell...	☐	☐
Heart attack/open heart surgery	☐	☐	Radiation treatment for tumor	☐	☐
Chest pain/angina	☐	☐	Previous cancer	☐	☐
High blood pressure	☐	☐	Thyroid disease or goiter	☐	☐
Stroke	☐	☐	Systemic/immune deficiency disorders	☐	☐
Artificial joint surgery/implant	☐	☐	Problems with anesthesia	☐	☐
Shortness of breath after exercise	☐	☐	Problems with surgery	☐	☐
Seizure, epilepsy, fainting	☐	☐	Problems with past dental treatment.	☐	☐
Diabetes or high blood sugar	☐	☐	If yes, what? ____________		
Hepatitis, jaundice, liver disease	☐	☐	Do you smoke or chew tobacco?	☐	☐
Arthritis or joint pain	☐	☐	If so, how much/day? ________		
Do you wear contact lenses?	☐	☐	Women, are you taking birth control?	☐	☐
Excessive use of alcohol/alcoholism	☐	☐	Are you pregnant? (__ months)	☐	☐
Use of recreational/illicit drugs	☐	☐	Are you nursing?	☐	☐

Name of Physician ____________ **City** ____________ **Phone** ____________

If there are any other medical problems or conditions you think I should be aware of, please describe:

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I UNDERSTAND THE ABOVE INFORMATION IS NECESSARY TO PROVIDE ME WITH DENTAL CARE IN A SAFE AND EFFICIENT MANNER. I HAVE ANSWERED EACH QUESTION COMPLETELY AND ACCURATELY TO THE BEST OF MY KNOWLEDGE. SHOULD FURTHER INFORMATION BE NEEDED, YOU HAVE MY PERMISSION TO ASK THE RESPECTIVE HEALTHCARE PROVIDER OR AGENCY, WHO MAY RELEASE SUCH INFORMATION TO YOU. I WILL NOT HOLD DR. KATZ OR ANY STAFF MEMBER RESPONSIBLE FOR ANY ERRORS OR OMISSIONS THAT I MAY HAVE MADE IN THE COMPLETION OF THIS FORM. I WILL NOTIFY THE DOCTOR OF ANY CHANGE IN MY HEALTH OR MEDICATION.

____________ Signature of Patient Date

____________ Signature of Dentist Date

Registration History

Paul C. Katz, D.D.S.
Nathalie Selvanathan, D.D.S.

Name ______________________ Birthdate __/__/__ Age ___ Marital Status ___

Address ______________________________ City ________________ Zip________

How long at this address _______ Home Phone ___________ Cell Phone __________

Business Address _______________________ City _______________ How long ____

Occupation _______________________________________ Work Phone ___________

Business Address _______________________ City _______________ How long ____

Occupation _______________________________________ Work Phone ___________

Person to notify in case of emergency _____________________ Relationship _______

Home Phone ______________ Cell Phone _____________ Work Phone ___________

Email Address__________________________________

Address ___________________________ City ________________ Phone _________

Physician __________________________ City ________________ Phone _________

Specialty ____________________ May we request your health records? ___________

Reason for this visit ____

Who referred you to our office? ____

Do you have dental insurance: Yes ____ No ____ If yes, please continue:
Employee Name __________________ ID/ SSN# _____________ Birthdate __/__/___
Employer ____________________ City ________________ Group/Policy# _________
Insurance Carrier Name _________________________ Phone (___) _______________
Insurance Address_______________________ City _____________ State___ Zip____
Do you have secondary dental coverage?
Employee Name __________________ ID/ SSN# _____________ Birthdate __/__/___
Employer ____________________ City ________________ Group/Policy# _________
Insurance Carrier Name _________________________ Phone (___) _______________
Insurance Address_______________________ City _____________ State___ Zip____

Payment for professional fees: Financial arrangements are to be made at the time appointments are scheduled. Any fees incurred are your personal responsibility, regardless of insurance coverage. However, we wish to assure you that we will do everything possible to help you obtain the benefits to which you are entitled.

Signature ____ Date ____________

PRISTINE FAMILY DENTISTRY
Your smile IS our mission

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8035 Madison Ave, suite F2
Citrus Heights CA 95610

HIPAA information and Consent

The health insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy.

A notice of Privacy practices should be available to you in the office. The notice provides information about how we may use and disclose protected health information about you in order to carry out treatment, payment, and healthcare operations, and for other purposes permitted or required by law. The notice also contains information about your rights under law.

Additional information is available from the U.S. Department of Health and Human Services.

By signing below you understand and agree to the terms of our notice of privacy practices which include:

- Protected health information may be disclosed or used for treatment, payment or healthcare operations.
- Authorization is required for certain disclosures of your Protected Health information.
- You have the right to opt out of fundraising communications.
- You have the right to restrict disclosures of your Protected Health information under certain circumstances.
- You have the right to be notified of a breach of unsecured Protected Health information.

By signing below you understand and agree that:

- The practice has a Notice of Privacy Practices that you have had the opportunity to review.
- The practice reserves the right to change the Notice of Privacy Practices and if we change our notice you may obtain a revised copy by contacting our office.
- You may revoke this consent in writing at any time and all future disclosures will cease.
- The practice may condition treatment upon the execution of this consent.

Patient Name:________________________________ Date:__________________

Signature:____________________________________

If not signed by patient, please indicate relationship:

____