

ORAL & MAXILLOFACIAL SURGERY ASSOCIATES of W.N.Y., P.C.

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HEALTH HISTORY

Print Patient Name: _____

Answer all questions by circling Yes (Y) or No (N)

All responses are kept confidential

1. Are you in good health? Y N
2. Has there been any change in your general health in the past year? Y N
3. Date of last physical exam _____
4. Are you now under a physician's care for a particular problem? Y N
5. Have you ever had any serious illnesses, operations or hospitalizations? If so, describe: Y N

- F. Tranquilizers? Y N
- G. Insulin or Oral Anti-Diabetic drugs? Y N
- H. Digitalis, Inderal, Nitroglycerin or other heart drug? Y N
- I. Any regular prescription medicine, pills or drugs ... Y N
If Yes, please list: _____
- J. Herbal or Holistic remedies, Vitamins or over-the-counter medications? Y N
If Yes, please list: _____

6. Height _____ Weight _____

7. **DO YOU HAVE OR HAVE YOU EVER HAD:**

- A. Rheumatic Fever or Rheumatic Heart Disease? Y N
- B. Congenital Heart Disease? Y N
- C. Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker?) Y N
- D. Lung Disease (Asthma, Emphysema, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing)? Y N
- E. Seizures, Convulsions, Epilepsy, Fainting, Dizziness, Psychiatric Treatment, or other Nervous Disorder? Y N
- F. Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion? Do you bruise easily? Y N
- G. Liver Disease (Jaundice, Hepatitis)? Y N
- H. Kidney Disease? Y N
- I. Diabetes? Y N
- J. Thyroid Disease (Goiter)? Y N
- K. Arthritis? Y N
- L. Stomach Ulcers or Colitis? Y N
- M. Glaucoma? Y N
- N. Implants placed anywhere in your body (Heart Valve, Pacemaker, Hip, Knee)? Y N
- O. Radiation (X-ray) treatment for Cancer? Y N
- P. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth? Y N
- Q. Sinus or Nasal problems? Y N
- R. Any disease, drug or transplant operation that has depressed your immune system? Y N
- S. HIV, AIDS or ARC? Y N

8. **ARE YOU USING ANY OF THE FOLLOWING:**

- A. Antibiotics? Y N
- B. Anticoagulants (Blood Thinners)? Y N
- C. Aspirin or drugs such as Motrin, Aleve, Ibuprofen? Y N
- D. High Blood Pressure medications? Y N
- E. Steroids (Cortisone, etc.)? Y N

9. **ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:**

- A. Local Anesthesia (Novocain, etc.)? Y N
- B. Penicillin or other antibiotics? Y N
- C. Sedatives, Barbiturates? Y N
- D. Aspirin or Ibuprofen? Y N
- E. Codeine or other pain killers? Y N
- F. Latex or Rubber Products? Y N
- G. Other allergies or reactions? Please, list Y N

10. Do you smoke or chew Tobacco? Y N
How much per day? _____

11. Is there any past history of Alcohol or Chemical Dependency or Emotional Disorder that may affect the care we provide you? Y N

12. Have you had any serious problems associated with any previous dental treatment? Y N

13. Have you or an immediate family member had any problem associated with intravenous anesthesia? Y N

14. Do you have any other disease, condition or problem not listed above that you think the doctor should know about? Y N

15. Do you wish to talk to the doctor privately about anything? Y N

16. **FEMALES ONLY**

A. Are you Pregnant, or **is there any chance** you might be Pregnant? Y N

B. Are you nursing? Y N

C. **If you are using Oral Contraceptives**, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.

I understand the importance of a truthful Health History to assist the doctor in providing the best care possible. I have had the opportunity to discuss my Health History with my doctor.

_____ Date

_____ Signature of Person Completing Health History

_____ Doctor's Initials

ORAL AND MAXILLOFACIAL SURGERY ASSOCIATES
OF WNY, PC

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

PATIENT GIVING CONSENT

Patient Name: _____

Guardian: _____

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 Practices: You have the right to read our Notice of Privacy Practices 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 contacting:

Contact Person: Donna Luh

Telephone: 716-675-9777

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect 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.

SIGNATURE

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

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

Oral & Maxillofacial Surgery Associates of WNY is authorized to disclose protected information to the following:

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Include completed Consent in the patient's chart.