BZD DENTAL ASSOCIATES, P.C.

d/b/a Holyoke Dental Associates, 610 South Street, Holyoke, MA 01040 (413)533-8378

Name – Last_____ First_____ MI_____ Date_____

Address (Street)_____ City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____ Date of Birth_____ S.S.#_____

If Student – School/College_____ Full Time/Part Time_____

Patient's Place of Employment_____ Position_____ Phone_____

Address_____

Spouse or Parent/Guardian's Name_____ Employer_____

Whom may we thank for referring you?_____

Person to contact in case of emergency_____ Phone_____ Cell_____

Physician_____ Phone_____ Reason for Appointment Today_____

Your e-mail address_____

MEDICAL HISTORY

Date of Last Physical Exam_____

High Blood Pressure	yes no	Mental Health issues	yes no	Any other allergic conditions	yes no
Heart Attack	yes no	Epilepsy	yes no	(List)_____	
Heart Murmur	yes no	Recent Weight loss/gain	yes no	Are you taking Coumadin?	yes no
Congenital Heart Defect	yes no	Depression	yes no	Do you take aspirin?	yes no
Hx of Endocarditis	yes no	Seizures	yes no	Do you take Fosamax or Boniva?	yes no
Pacemaker	yes no	Arthritis	yes no	Any other Biophosphonates?	yes no
Defibrillator	yes no	Osteoporosis	yes no	Have/do you smoke tobacco?	yes no
Mitral Valve Prolapse	yes no	Hay Fever/Seasonal		Use controlled substances?	yes no
Low Blood Pressure	yes no	or Food Allergies	yes no	Use narcotics/rec drugs?	yes no
Thyroid Disease	yes no	Joint Replacement	yes no	Chew tobacco?	yes no
Angina	yes no	Cancer (type)_____	yes no	Women – Are you pregnant?	yes no
Emphysema	yes no	Hepatitis (type)_____	yes no	Take Birth Control Pills?	yes no
Chemotherapy/Radiation	yes no	HIV/AIDS	yes no	**Medications (Please list all):**	
Asthma	yes no	Herpes	yes no	_____	
Glaucoma	yes no	Sexually Trans Disease	yes no	_____	
Kidney Disease	yes no	History of Shingles	yes no	_____	
Liver Disease	yes no	Tuberculosis	yes no	_____	
Respiratory Disease	yes no	Bulimia/Anorexia	yes no	_____	
Stroke	yes no	Diabetes	yes no	**Are you allergic or have you had a reaction to:**	
Leukemia	yes no	Blood Disorder	yes no	Latex_____	Local Anesthesia_____
Ulcers	yes no	Anemia	yes no	Sulfa Drugs_____	Penicillin_____
Neurological Disease	yes no			Any Antibiotics_____	
				Metal (Nickel, Mercury, etc.)_____	

Signature_____ Date_____ Doctor's Initials_____

Signature (Follow-up Visit)_____ Date_____ Doctor's Initials_____

RELEASE OF INFORMATION – SIGNATURE ON FILE

I authorize BZD Dental Associates, PC to release medical or other information (which may include photocopies of medical and/or dental histories, x-ray findings; diagnosis, treatment, prognosis and financial records) without limitations in order to determine benefits for treatment, or in conjunction with a related insurance claim.

I permit a copy of this authorization to be used in place of the original, and request payment of benefits to either myself or the party who accepts assignment.

I am aware that the payment quoted is an estimate for services rendered and there is no guarantee of payment from my insurance company.

I am aware that I am responsible for any and all charges not covered by my insurance company or other third party payer.

Signature of PatientorParent/Guardian_____ Date_____

HIPAA CONSENT:

- When you receive treatment at BZD Dental Associates, PC, information will be collected about you and this office will generate information about your medical/dental condition. This private health information falls under Federal Regulation within a law called the Healthcare Information Portability and Accountability Act (HIPAA). This information may be used or disclosed for treatment, payment or to carry out healthcare operations.
- There is a Notice of Privacy Practices posted in this office and available to you regarding the use of your private medical information. You have a right to review this document before giving consent for your care.
- You have the right to request BZD Dental Associates, PC restrict how your medical information is used or disclosed, but BZD Dental Associates, PC has the right not to agree with your request. If BZD Dental Associates, PC agrees to restrictions, they are binding on the providers and staff.
- You have the right to revoke your consent to use your health information, except to the extent that your provider has already taken action based on previous consent.
- If you do not consent to this health information policy, BZD Dental Associates, PC reserves the right not to provide you with care and to arrange for care from someone else. We will not refuse or restrict your care in an emergency.
- If you want more information about our privacy practices, please ask the Front Desk Staff for the name/phone number of the HIPAA Privacy Officer for BZD Dental Associates, PC.

Signature of Patient or Parent/Guardian_____ Date_____

AUTHORIZATION TO SHARE PRIVATE HEALTH INFORMATION (OPTIONAL)

If you wish to grant permission to our staff to speak with a family member or friend regarding your private health information – including your billing account – please complete the following. It will remain in effect until it is revoked by you or updated with new information, whichever comes first.

If you leave this section blank, it will be considered a revocation of any previous authorization.

I give permission to the staff of BZD Dental Associates, PC to release my private health information and billing account information to the following individual(s) if requested by them:

Name: Relationship to Patient:

_____

_____

_____

_____

Signature of Patient (or parent if minor)_____ Date_____