DAVID CIRCEO, DDS,PC
804-262-9824
6113 LAKESIDE AVE.
RICHMOND, VA 23228

PATIENT INFORMATION

Name_____ Preferred name_____
Address_____
City, State Zip _____
Phone Home_____ Work_____
Pager_____ Cell_____
Male/Female Marital status_____ Date of birth_____
Social Security #_____
E-mail_____

RESPONSIBLE PARTY INFORMATION

Name_____ Relationship to Patient_____
Address_____
City State, Zip_____
Phone Home_____ Work_____
Pager_____ Cell_____
Male/Female Marital status_____ Date of birth_____
Social Security #_____

INSURANCE INFORMATION

Name of Subscriber_____Date of birth_____
Subscriber ID#_____
Insurance Co. Name_____Insurance Co Phone # _____
Employer_____ Group #_____

SECONDARY INFORMATION

Name of Subscriber_____
Subscriber ID#_____
Insurance Co. Name_____ Insurance Co Ph #_____
Employer_____ Group #_____

Who may we thank for referring you? _____

Health History Form

Name:_____ Home Phone _____Business Phone_____
Last First Middle

Address_____ City _____State_____ Zip Code_____
PO Box or Mailing address

Occupation_____Height_____Weight_____ Date of Birth___/___/___ Sex ☐M ☐ F

Emergency Contact_____Relationship_____Phone_____

If you are completing this form for another person, what is your relationship to that person _____
Name Relationship

For the following questions, please (X) whichever applies, your answers are for our records only and will be kept confidential in accordance with applicable laws. Please note that during your visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Dental Information

Yes	No	Don't Know		Yes	No	Don't Know	
☐	☐	☐	Do your gums bleed when you brush?	☐	☐	☐	Have you ever had orthodontic (braces) treatment?
☐	☐	☐	Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐	Do you have headaches, earaches or neck pain?
☐	☐	☐	Have you had any periodontal (gum) treatments?	☐	☐	☐	Do you wear removable dental appliances?
☐	☐	☐	Have you had a serious/difficult problem associated with any previous dental treatment? If so, explain _____				

_____

How would you describe your current dental problem?_____

Date of your last dental exam? _____Date of last x-rays_____

What was done at that time? _____

How do you feel about the appearance of your teeth? _____

Medical Information

Yes	No	Don't Know	
☐	☐	☐	Are you in good health?
☐	☐	☐	Has there been any change in your general health within the past year?

Do you have any of the following diseases or problems? **If you answer yes to any of the 3 items below, please stop and return this form to the receptionist.**

☐	☐	☐	Active Tuberculosis
☐	☐	☐	Persistent cough greater than a 3 week duration
☐	☐	☐	Cough that produces blood
☐	☐	☐	Are you now under the care of a physician? If so, what is/are the condition(s) being treated?_____ _____Date of last physical exam_____ Physicians(s) _____ _____
☐	☐	☐	Have you had any serious illness, operation, or been hospitalized in the past 5 years? If so, what medicine(s) are you taking? Prescribed _____ Over the counter _____ Natural or herbal preparations _____
☐	☐	☐	Are you taking, or have you taken, any diet drugs such as Pondimin (fendluramine), Redux (dexphenfuramine) or phen-fen(phentermine)?
☐	☐	☐	Do you drink alcoholic beverages? If yes, how much alcohol did you drink in the last 24 hours_____ In the past month? _____ If yes, _____# of drinks per day for _____# years
☐	☐	☐	Are you alcohol and/or drug dependent? If so, have you received treatment? (Check one) YES NO
☐	☐	☐	Do you use drugs or other substances for recreational purposes? If yes, please list _____ Frequency of use (daily, weekly, etc) _____Number of years of recreational drug use _____
☐	☐	☐	Do you use tobacco (smoking, snuff, chew)? If so, how interested are you in stopping? (Check one) Very Somewhat Not interested
☐	☐	☐	Do you wear contact lenses?

Allergies Are you allergic to or have you had a reactions to: (Please fill out both columns)

Yes	No	Don't Know		Yes	No	Don't Know	
☐	☐	☐	Local anesthetics	☐	☐	☐	Latex
☐	☐	☐	Aspirin	☐	☐	☐	Iodine
☐	☐	☐	Penicillin or other antibiotics	☐	☐	☐	Hay Fever/seasonal
☐	☐	☐	Barbiturates, sedatives or sleeping pills	☐	☐	☐	Animals
☐	☐	☐	Sulfa drugs	☐	☐	☐	Food (specify)
☐	☐	☐	Codeine or other narcotics	☐	☐	☐	Other (Specify)

To yes responses, specify type of reaction_____

Please complete both sides

Yes	No	Don't Know	
☐	☐	☐	Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? If so when was this operation done?_____
☐	☐	☐	Have you had any complications or difficulties with your prosthetic joint?
☐	☐	☐	Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? If so, what antibiotic and dose?
			Name of physician or dentists _____Phone _____
(Women Only)			
☐	☐	☐	Are you pregnant?
☐	☐	☐	Nursing?
☐	☐	☐	Taking birth control pills?

Please (X) if you have or had any of the following diseases

Yes	No	Don't know		Yes	No	Don't Know		Yes	No	Don't Know	
☐	☐	☐	Abnormal bleeding	☐	☐	☐	Disease, drug or radiation	☐	☐	☐	Neurological disorders
☐	☐	☐	AIDS or HIV infection				induced immunosuppression				If yes, specify _____
☐	☐	☐	Anemia	☐	☐	☐	Diabetes, If yes specify below	☐	☐	☐	Osteoporosis
☐	☐	☐	Arthritis				○ Type I	☐	☐	☐	Persistent swollen glands in neck
☐	☐	☐	Rheumatoid arthritis				○ Type II	☐	☐	☐	Respiratory problems
☐	☐	☐	Asthma	☐	☐	☐	Dry Mouth				If yes, specify below
☐	☐	☐	Blood transfusion	☐	☐	☐	Eating disorder				○ Emphysema
			If yes date_____				If Yes, specify_____				○ Bronchitis, etc
☐	☐	☐	Cancer/Chemotherapy/radiation	☐	☐	☐	Epilepsy	☐	☐	☐	Severe headaches
			Treatment	☐	☐	☐	Fainting spells or seizures	☐	☐	☐	Severe or rapid weight loss
☐	☐	☐	Cardio vascular disease	☐	☐	☐	GE reflux	☐	☐	☐	Sexually transmitted disease
			If yes, specify below	☐	☐	☐	Glaucoma	☐	☐	☐	Sinus trouble
			○ Angina	☐	☐	☐	Hemophilia	☐	☐	☐	Sleep disorder
			○ Arteriosclerosis	☐	☐	☐	Hepatitis, jaundice or liver disease	☐	☐	☐	Sores or ulcers in the mouth
			○ Artificial heart valves	☐	☐	☐	Recurrent infections	☐	☐	☐	Stroke
			○ Coronary insufficiency				indicate type of infection	☐	☐	☐	Systemic lupus erythematosus
			○ Coronary occlusion				_____	☐	☐	☐	Thyroid problems
			○ Damaged heart valves	☐	☐	☐	Kidney Problems	☐	☐	☐	Tuberculosis
			○ Heart attack	☐	☐	☐	Low Blood pressure	☐	☐	☐	Ulcers
			○ Heart murmur	☐	☐	☐	Mental health disorder	☐	☐	☐	Excessive urination
			○ High Blood pressure				If yes, specify below	☐	☐	☐	Do you have any disease
			○ Inborn heart defects				_____				condition or problem not listed
			○ Pacemaker				_____				above that you think I should
			○ Mitral valve prolapse	☐	☐	☐	Malnutrition				know about? Please explain
			○ Rheumatic heart disease	☐	☐	☐	Migraines				_____
☐	☐	☐	Chest pain upon exertion	☐	☐	☐	Night sweats				_____
☐	☐	☐	Chronic Pain								
☐	☐	☐	Persistent diarrhea								

NOTE: Both doctor and patients are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquires set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of error or omission that I may have made in the completion of this form.

_____ _____
Signature of Parent/Legal Guardian Date

For completion by dentist

Comments on patient interview concerning heath history _____
_____
_____

Significant findings from questionnaire or oral interview_____
_____
_____

Dental management considerations_____
_____

_____ _____
Signature of Dentist Date

Health History Update

Date	**Comments**	**Signature of patient or dentist**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Smile....it's good for business
David C. Circeo DDS

SUMMARY NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information.

USES AND DISCLOSURES: We will use and disclose elements of your protected heath information (PHI) in the following ways:

- For purposes of treatment, payment and practice operations.
- When release is required by law, including military purposes, law enforcement requests, national security reasons, or for healthcare regulatory/accrediting agencies.
- In emergency situations or for health and safety reasons.
- To medical examiners, coroners, or funeral directors.
- To organ, tissue, and other donation organizations.
- To contact you about appointment reminders or to tell you about other health-related benefits and services.
- For Worker's Compensation requests.
- For clinical research purposes.
- To people who are involved in your care.

All other uses and disclosures will require us to obtain a written authorization from you.

YOUR RIGHTS:

- Restrictions: To ask us to limit the information we share. (The request will be considered on an individual basis.)
- Confidential communications: To receive your confidential health information by alternate addresses, telephone numbers, or fax numbers.
- Access: To inspect or receive copies of your medical record.
- Amendments: To request changes be made to your health information. (The request will be considered on an individual basis.)
- Accounting: To receive a list of our disclosures of your health information.
- This notice: To ask for a copy of our full privacy notice.
- Complaints: To complain to Dr. David Circeo or the U.S. Department of Health & Human
- Services Office of Civil Rights. To file a complaint, call our Privacy Officer at 804-262-9824.

OUR DUTIES: We are required by law to maintain the privacy of your Protected Health Information. We must abide by the terms of this notice; effective April 14, 2003.

PRIVACY CONTACT: For more information about our privacy practices, please contact our Privacy Officer at 804-262-9824

DAVID C. CIRCEO DDS, PC.
6113 Lakeside Avenue
Richmond, Virginia 23228

Ph.: 804-262-9824
Fax: 804-264-2834

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE

I, _____, acknowledge that I have received a Notice of Privacy Practices from the above-named practice.

Signature: _____ Date _____
If a personal representative signs this authorization on behalf of the individual, complete the following:

Personal Representative's Name: _____
Relationship to Individual: _____

DAVID CIRCEO, DDS,PC
804-262-9824
6113 LAKESIDE AVE.
RICHMOND, VA 23228

INSURANCE AUTHORIZATION, ASSIGNMENT AND RELEASE

I certify all information provided is correct to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance to release the assignment of benefits directly to the dentist otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

We are glad to assist you in securing payment of claims, but ask that you pay your estimated portion when services are rendered. In fairness to the dentist, patients must understand insurance is a contract between the patient and the insurance company.

Payment of professional fees is due in full, unless arrangements are approved prior to treatment.

We accept cash, checks, Mastercard, Visa and Discover.

As a service to our patients who are covered by insurance, the office can assist in filing the insurance claim. Any co-payments, however, are due when services are rendered.

The fee for a returned check is $35.00

We reserve the right to charge a $35 missed-appointment fee **per** appointment time if cancelled within 24 hours of the appointment time.

I agree to be responsible for payment of all services rendered on behalf of my dependents and myself. If payment is not received within 30-days of service, collection proceedings may ensue. I will be responsible for collections fee, attorney's fees and court costs pursuant to collection.

Signature_____ Date_____
Patient/Responsible Party (if a minor)