

Prosthodontics Associates, NYC, PLLC

655 Madison Avenue, New York, NY 10065 212 751 2544

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Please Read the Following Statements Carefully before Signing Form

Purpose of Consent: By signing this form, you 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, which will contain the changes. Those changes may apply to protected health information that we maintain.

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 Prosthodontic Associates P.C., 655 Madison Avenue, New York, NY 10021. Please understand that revocation of this Consent will not affect any action we took relying on this Consent before we received your revocation, and that we may decline to treat you, or continue to treat you, if you revoke this Consent.

Signature:

I, *(print)* _____, have received and 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 healthcare.

Signature: _____ Date: _____

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

Name: *(print)* _____ Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
THIS CONSENT WILL BE A PERMANENT DOCUMENTS IN YOUR CHART IN THIS OFFICE.

Caroline A. Grasso, DDS
Harold Litvak, DMD
Michael D. Litvak, DDS
Udo Schutte, DDS



655 Madison Avenue
New York, NY 10065
212-751-2544

Patient History & Information

(confidential information for your file)

Date _____
Soc. Sec. # _____

Name _____
Last Name Mr. Mrs. Miss First Name

Birth Date _____

Res. Address _____
Street City State Zip

Res. Phone _____

Bus. Address _____
Street City State Zip

Bus. Phone _____

Occupation _____ Bill to _____

Cell Phone _____

Whom may we thank for referring you to this office? _____

Physician _____ Telephone _____

Dental Insurance Carrier _____ Group No. _____

Emergency Contact _____ Phone _____

Marital Status (circle) Single Married Widowed Divorced Circle Yes or No

- Are you now under the care of a physician YES NO
A. If so, what is the condition being treated? _____
- Are you in good health YES NO
- My last physical exam was on _____
- Has there been any change in your general health within the past year YES NO
- Have you ever been seriously ill YES NO
- Have you ever been hospitalized YES NO
Please list all hospital admissions/operations and year

7. Are you taking any medication (including aspirin or aspirin like compounds for headaches, etc.) YES NO
What kind? _____

8. List any medication you have taken during the past year other than the above.

9. Circle any of the following which you have had
- | | | |
|------------------------------|-------------------------------|------------------------------------|
| Congenital heart lesions | Hepatitis (jaundice) | IV Drug use |
| Heart murmur or defect | Kidney disease | Drug addiction |
| Rheumatic fever | Liver disease | Alcoholism |
| Heart attack | Blood disorder (anemia) | Glaucoma |
| Heart trouble | Endocrine (thyroid) disorder | Radiation/chemotherapy |
| Mitral valve prolapse | Embolism | Arthritis |
| (Systolic click syndrome) | Persistent cough | Epilepsy |
| High/low blood pressure | Nervous disorder | Frequent headaches |
| Asthma | Psychiatric treatment | Fainting spells or seizures |
| Emphysema | Ulcers | Pacemaker |
| Tuberculosis or lung disease | Veneral disease | Hearing aid |
| Diabetes | (or any communicable disease) | Any foreign implants |
| Stroke | AIDS Related Complex | Blood transfusion (see other side) |

- 10. Do you bruise easily YES NO
- 11. Have you had any excessive bleeding from an injury or tooth extraction YES NO
- 12. Do you get hives or skin rashes. YES NO
- 13. Are you allergic or have you ever had an unusual reaction to a dental anesthetic, penicillin, barbituates, aspirin, codeine, sulfa, other _____
- 14. Do you have chest pain upon exertion YES NO
- 15. Do you have painful or swollen joints YES NO
- 16. Do you exhaust or fatigue easily YES NO
- 17. Do you have excessive urination and/or thirst YES NO
- 18. Have you been treated for a growth or tumor. YES NO
- 19. (Women) Are you pregnant YES NO
- 20. Are you wearing contacts YES NO
- 21. Do you smoke cigarettes, cigars, pipe YES NO
- 22. Do you have any disease, condition or problem not listed above that I should know about YES NO
- 23. Is this visit due to an accident or injury YES NO

Patient's Signature _____

Date _____

DATE	SIGNATURE	CHANGES

DENTAL HISTORY

- 1. Have you been having a specific problem YES NO
- 2. Do your gums bleed YES NO
- 3. Are you troubled with bad breath YES NO
- 4. Do you have sensitive teeth YES NO
- 5. Do you have sinus trouble YES NO
- 6. Have you ever had
 - Injury to face, jaws, teeth Oral surgery
 - Orthodontic treatment Periodontal (gum) surgery
- 7. Have you noticed any loosening o your f teeth YES NO
- 8. Do you have, or have you had, any TMJ problems - clicking, locking, or pain YES NO