Name:_____DOB:_____/_____/_____Age:_____Gender:_____

SS:_____-_____-_____Dental Insurance:_____

Address:_____City/State/Zip:_____

Cell:(_____)_____ Home:(_____)_____Work:(_____)_____

Employer:_____Occupation:_____

Present Dentist:_____Present Physician:_____

Emergency Contact:_____Phone: (____)_____Relationship:_____

Preferred Pharmacy (Name/City):_____Phone:_____

Medical History

1. Have you ever had:

a) An adverse or **allergic reaction to any medications** including local anesthetics, penicillin, codeine, aspirin or any other antibiotics? An allergic reaction to latex? Yes____No____
If yes, please explain:_____

b) A heart or blood disorder, rheumatic fever, chest pain, palpitation, pacemaker, high/low blood pressure or excessive bleeding? Yes____No____
If yes, please explain:_____

c) A lung or respiratory disorder, tuberculosis, persistent coughing, difficulty swallowing, asthma, sleep apnea or hay fever? Yes____No____
If yes, please explain:_____

d) A stomach, liver or intestinal disorder, ulcer, colitis, hepatitis or cirrhosis? Yes____No____
If yes, please explain:_____

e) A kidney, bladder or urinary disorder? Sugar, albumin, blood or pus in urine? Yes____No____
If yes, please explain:_____

f) A brain or nervous system disorder, mental illness, dizziness, fainting, epilepsy, severe or frequent headaches? Yes____No____
If yes, please explain:_____

g) A skin or gland disorder, diabetes, thyroid problems, dermatitis or syphilis? Yes____No____
If yes, please explain:_____

h) A bone or joint disorder, arthritis, rheumatism, gout or osteoporosis? Yes____No____
If yes, please explain:_____

i) An eye, ear, nose or throat disorder? Yes____No____
If yes, please explain:_____

2. **Have you ever been hospitalized or had a surgical operation?** Yes____No____
If yes, please explain:_____

3. **Have you ever tested positive for H.I.V., AIDS, cancer, cyst or tumor?** Yes____No____
If yes, please explain:_____

4. **Are you presently in good health?_____** Yes____No____

5. Are you currently taking any medications (including birth control, aspirin or blood thinners)? Have you ever taken Fosamax (osteoporosis)? Yes____No____
If yes, please list:_____

_____

6. **For our female patients: Are you pregnant?** Yes____No____
If yes, please specify due date:_____

7. **Are there any foods that you are allergic to?** Yes____No____
If yes, please list:_____

8. Do you use a CPAP machine (for sleep apnea)? Yes____No____

9. Do you smoke? Yes____No____
Please circle type and indicate how many per day:
Cigarettes_____ Pipe_____ Cigar _____ Smokeless tobacco_____

Dental History

1. Are you aware or concerned about:
a) Pain or discomfort in the face, ear, neck, mouth, gums or teeth? Yes____No____
b) Loose teeth, offensive breath or bleeding gums? Yes____No____
c) Cracking or popping of the jaw or difficulty chewing? Yes____No____
d) Poorly fitting oral appliance or denture? Yes____No____
e) Grinding or clenching of teeth, biting of lips or cheeks? Yes____No____

2. Have you ever consulted a periodontist or orthodontist in the past? Yes____No____
3. Have you ever had an unpleasant dental experience? Yes____No____
4. Do you have dental implants or would you like to discuss the possibility of dental implants? Yes____No____

Please circle the following oral hygiene aids that you utilize:

Manual Toothbrush	Floss	Rubber Tip Stimulator
Electric Toothbrush	Water Irrigator	Others:_____

If you have any other concerns that you would like to discuss with Dr. Sogoloff, please write them down below:

_____

I understand that I am responsible for full payment of my bill in a timely manner. I authorize payment of any dental benefits directly to Dr. Sogoloff if applicable. I authorize use of my protected health information (PHI) to carry out treatment, payment, and healthcare operations. I authorize Dr. Sogoloff or his staff to contact my house or other designated location and leave messages to assist in providing treatment, payment and healthcare operations. I authorize Dr. Sogoloff or his staff to send information and statements to my home or designated address and share necessary protected health information with other healthcare providers associated with my dental treatment. I understand that I have the right to review Dr. Sogoloff's privacy statement. I have the right to revoke my consent in writing, except for disclosures already made prior to the office receiving such notice. I understand that Dr. Sogoloff has the right to refuse treatment if consent is not given.

_____ _____

Signature of responsible party **Date**

(Barry A. Sogoloff, D.M.D., M.S.)

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _(_____)_____ E-mail (Optional): _____

Social Security Number (Optional): _____

SECTION B: 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: Barry A. Sogoloff, D.M.D., M.S.
Telephone: (216) 292-6787 – Fax (216) 765-1772
Address: 23250 Chagrin Boulevard, Suite 205 – Beachwood, Ohio 44122

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.

I, _____, have had full opportunity to read and consider the consents 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 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 the Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT
Include completed Consent in the patient's chart

Records Request

Date_____

Patient Name:_____

Records:_____

_____Treatment Request

_____X-rays

Notes:_____

_____

_____

_____

Requesting records from:

_____.

_____.

_____.

Records should be sent to:

Dr. Barry A. Sogoloff D.M.D., M.S.
23250 Chagrin Blvd.
Bldg. 5, Suite 205
Beachwood, Ohio 44122

Office Phone Number: 216-292-6787
Office Fax Number: 216-765-1772

_____

Authorized Signature (patient, parent or guardian) Date