Patient Health Record

In order for us to render the proper dental services to you, would you be kind enough to answer the following questions. Thank tou for your cooperation.

DATE _____

NAME OF PATIENT (Last) (First) (Middle)

DATE OF BIRTH SEX PATIENT'S SOCIAL SECURITY # OCCUPATION

ADDRESS # STREET APT# CITY ZIP CODE HOME PHONE #

CARDHOLDER"S NAME (EMPLOYEE) EMPLOYEE SOCIAL SECURITY # EMPLOYEE'S DATE OF BIRTH

NAME OF INSURANCE CO. NAME OF EMPLOYER WORK PHONE #

SPOUSE'S NAME NAME OF CLOSE FRIEND OR RELATIVE – PHONE #

REFERRED BY IN CASE OF EMERGENCY, PERSON &PHONE # TO CALL

HEALTH HISTORY

GENERAL HEALTH (CHECK ONE)

EXCELLENT( ) GOOD ( ) FAIR ( ) POOR ( )

NAME OF PHYSICIAN ADDRESS PHONE #

- ARE YOU TAKING ANY MEDICATIONS ? YES ( ) NO( ) WHAT MEDICATIONS AND FOR WHAT REASON ? _____
- ARE YOU ALLERGIC TO: PENNICILLIN ( ) CODEINE ( ) LOCAL ANESTHESIA ( ) OR OTHERS _____
- ARE YOU SUBJECT TO PROLONGED BLEEDING? YES ( ) NO ( )
- (WOMEN ONLY) - ARE YOU PREGNANT ? YES ( ) NO ( )
  ARE YOU TAKING BIRTH CONTROL PILLS ? YES( ) NO ( )

HAVE YOU EVER BEEN TREATED FOR:

HEART DISEASE .....YES ( ) NO ( )
RHEUMATIC FEVER .....YES ( ) NO ( )
ABNORMAL BLOOD PRESSURE.....YES ( ) NO ( )
ULCER.....YES ( ) NO ( )
TUBERCULOSIS OR LUNG DISEASE ....YES ( ) NO ( )
EPILEPSY.....YES ( ) NO ( )
ANEMIA.....YES ( ) NO ( )
CONGENITAL HEART LESIONS.....YES ( ) NO ( )
AIDS OR HIV VIRUS .....YES ( ) NO ( )

HEART MURMR.....YES ( ) NO ( )
JAUNDICE.....YES ( ) NO ( )
ASTHMA.....YES ( ) NO ( )
HAY FEVER.....YES ( ) NO ( )
DIABETES.....YES ( ) NO ( )
SINUS TROUBLE.....YES ( ) NO ( )
HEPATITIS.....YES ( ) NO ( )
ARTHRITIS.....YES ( ) NO ( )
STROKE.....YES ( ) NO ( )

PATIENT OR GUARDIAN'S SIGNATURE _____ DATE _____ DOCTOR'S SIGNATURE _____

Abuse or Neglect

We will notify government authorities if we believe a patient is the victim of abuse, neglect or domestic violence. We will make this disclosure only when we are compelled by our ethical judgment, when we believe we are specifically required or authorized by law or with the patient's agreement.

Public Health and National Security

We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health or national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment or medical device.

For Law Enforcement

As permitted or required by State or Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of a crime or in order to report a crime.

Family, Friends and Caregivers

We may share your health information with those you tell us will be helping you with your home hygiene, treatment, medications, or payment. We will be sure to ask your permission first. In the case of an emergency, where you are unable to tell us what you want we will use our very best judgment when sharing your health information only when it will be important to those participating in providing your care.

Authorization to Use or Disclose Health Information

Other than is stated above or where Federal, State or Local law requires us, we will not disclose your health information other than with your written authorization. You may revoke that authorization in writing at any time.

Patient Acknowledgment

Patient Name(s):_____

_____

_____

Thank you very much for taking time to review how we are carefully using your health information. If you have any questions we want to hear from you. If not, we would appreciate very much your acknowledging your receipt of our policy by signing and returning this card. We look forward to seeing you again soon!

_____

Patient Signature

Date _____/_____/_____

Patient Rights

This new law is careful to describe that you have the following rights related to your health information.

Restrictions

You have the right to request restrictions on certain uses and disclosures of your health information. Our office will make every effort to honor reasonable restriction preferences from our patients.

Confidential Communications

You have the right to request that we communicate with you in a certain way. You may request that we only communicate your health information privately with no other family members present or through mailed communications that are sealed. We will make every effort to honor your reasonable requests for confidential communications.

Inspect and Copy Your Health Information

You have the right to read, review, and copy your health information, including your complete chart, x-rays and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable fee to duplicate and assemble your copy.

Amend Your Health Information

You have the right to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe your reason for the change.

Your request may be denied if the health information record in question was not created by our office, is not part of our records or if the records containing your health information are determined to be accurate and complete.

Documentation of Health Information

You have the right to ask us for a description of how and where your health information was used by our office for any reason other than for treatment, payment or health operations. Our documentation procedures will enable us to provide information on health information usage from April 14, 2003 and forward. Please let us know in writing the time period for which you are interested. Thank you for limiting your request to no more than six years at a time. We may need to charge you a reasonable fee for your request.

Request a Paper Copy of this Notice

You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time. Stop by or give us a call and we will mail or email a copy to you.

We are required by law to maintain the privacy of your health information and to provide to you and your representative this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our Notice. If we change our privacy practices we will be sure all of our patients receive a copy of the revised Notice.

You have the right to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. Please let us know of your concerns or complaints in writing.

Instructions after surgical extraction

After a surgical extraction:

1. BLEEDING – Bite down on gauze with a lot of pressure for about 1 hour, make sure you change gauze every 15 – 20 minutes. It is recommended to take 2 tablets of extra strength Tylenol or Ibuprofen every 4 hours till bedtime. A certain amount of bleeding is normal after any extraction, but if bleeding continues excessively, repeat the process or if its too much look for your dentist for an examination.

2. PAIN – Mild discomfort is usually experienced after any surgical procedure, of which extra – strength Tylenol or Ibuprofen will alleviate. If that is not sufficient, one should obtain the pain medication as prescribed by the dentist.

3. SWELLING – With more complicated extractions, swelling may occur. Application of ice packs every 15 minutes should reduce swelling.

4. RINSES – No vigorous rinsing at the same day of extraction, these will cause prolonged bleeding. The next day, a rinse with water and salt solution is recommended to do 5 – 10 times every day, for 7 days. These rinses are essential for healing and keeping it clean. During the healing process, one should avoid eating on that side of mouth.

5. BONE CHIPS – During the healing process, it is common that small fragments of bone may be released from surgical site, that is a normal healing process. Should there be any discomfort due to the bone pieces, return to the office for its removal.

6. PAIN and SWELLING – If pain or swelling occurs after healing of the surgical site, one should return to the office for examination.

Any problems or questions, feel free to contact us:
GEORGE J. SAWAN, D.M.D.
JOSEPH S. SAWAN, D.M.D.
2 IRVING STREET
FRAMINGHAM, MA 01702
(508) 620-7162