



Tony T. Athans D.D.S.
MODERN DENTAL INNOVATIONS
1707 Shermer Rd., Suite 125
Northbrook, IL 60062
847-498-3333

Notice of Privacy Practices Acknowledgment

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

Obtain payment from third-party payers.

Conduct normal healthcare questions such as quality assessments and physical certifications.

I acknowledge that I have received your **Notice of Privacy Practices** containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its **Notice of Privacy Practices** from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the **Notice of Privacy Practices**.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

Office use only

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: _____ Initials: _____

Reason: _____



Tony T. Athans D.D.S.
MODERN DENTAL INNOVATIONS
1707 Shermer Rd., Suite 125
Northbrook, IL 60062
847-498-3333

PATIENT INFORMATION

_____			Birthdate _____	
Last	First	Middle		
Resident Address _____				
Street		City	Zip	Phone
E-mail _____			Cell Phone _____	
Employer _____		Occupation _____	No./yrs _____	
Address _____				
Street		City	Zip	Phone
Do you have dental insurance? Yes No		Your Social Security No. _____		
Marital Status: M W S D		Name of Spouse _____		
Spouse's Employer _____			No./yrs _____	
Address _____				
Street		City	Zip	Phone
Who is responsible for your account? _____			Soc. Sec. # _____	
Who may we thank for referring you to our office? _____				

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient Signature

Date



Tony T. Athans D.D.S.

MODERN DENTAL INNOVATIONS

1707 Shermer Rd., Suite 125

Northbrook, IL 60062

847-498-3333

MEDICAL INFORMATION HISTORY

CIRCLE THE APPROPRIATE ANSWER. YOUR ANSWERS WILL BE CONFIDENTIAL.

Yes No Are you taking any blood thinners? If yes, what? _____

Yes No Are you taking any medication, drugs or pills? If yes, what? _____

Yes No Are you presently in good health?

Yes No Have you been under a physician's care in the last 2 years?
 Last Medical Exam _____ Name of Physician _____

ARE YOU ALLERGIC TO OR TOLD NOT TO TAKE:

Yes No Penicillin

Yes No Codeine

Yes No Others (Please Specify) _____

HAVE YOU EVER BEEN TREATED FOR OR DO YOU HAVE:

Yes	No	Heart disease	Yes	No	Tuberculosis or lung disease
Yes	No	Rheumatic fever	Yes	No	Asthma or hay fever
Yes	No	High blood pressure	Yes	No	Allergies (including jewelry)
Yes	No	Shortness of breath	Yes	No	Persistent cough
Yes	No	Pain, pressure in chest	Yes	No	Epilepsy
Yes	No	Anemia	Yes	No	Fainting spells
Yes	No	Excessive bleeding	Yes	No	Sinus trouble
Yes	No	Heart murmur	Yes	No	Nervous problems
Yes	No	Mitral Valve Prolapse	Yes	No	Cancer
Yes	No	Artificial heart valves	Yes	No	Arthritis
Yes	No	Stroke	Yes	No	Diabetes
Yes	No	Jaundice	Yes	No	Ear problems
Yes	No	Hepatitis	Yes	No	Recent Surgery
Yes	No	Glaucoma			If yes, what? _____
Yes	No	Ulcers	FOR WOMEN:		
Yes	No	A.I.D.S.	Yes	No	Are you pregnant?
Yes	No	Herpes			Due date? _____
Yes	No	Prosthetic Joints (i.e. knee, hip etc.)	Yes	No	Are you on birth control pills?
Yes	No	Do you have any other condition/disease that we should know about?			
Yes	No	May we contact your physician regarding your medical history?			

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient Signature

Date



Tony T. Athans D.D.S.
MODERN DENTAL INNOVATIONS
1707 Shermer Rd., Suite 125
Northbrook, IL 60062
847-498-3333

DENTAL HISTORY

- Yes No Are you presently having any dental problems?
If yes, please describe _____
When was your last dental visit? _____
- Yes No Have you had any problems or upsetting experience associated with any previous dental treatment?
What is your reaction to having dental work done: (Circle one:)
Dread it? Worry about it? Don't mind it?
- Yes No Have you ever experienced any problems with dental anesthetics?
Yes No Have you had orthodontic treatment (braces)?
Yes No Have you lost any permanent teeth (including wisdom)?
Yes No If yes, were missing teeth replaced?
- Yes No Do your gums bleed when you brush your teeth?
Yes No Does food catch between your teeth?
Yes No Do any teeth feel loose?
Yes No Do you have any unpleasant odor or taste in your mouth?
Yes No Have you ever been treated for periodontal (gum) disease?
- Are any teeth sensitive?
Yes No To heat
Yes No To cold
Yes No To sweets
Yes No When chewing
- Yes No Do you clench or grind your teeth while awake or asleep?
Yes No Do you have chronic headaches, or neck and shoulder pain?
Yes No Do you now, or have you ever had, pain in your jaw joint or the sides of your face (in and around the ears)?
Yes No Do you have a clicking jaw joint or have you ever experienced an inability to move your jaw or open your mouth widely?
Yes No Have you ever had your bite adjusted?
Yes No Have you ever worn a nightguard or any other appliance?

If you could wave a magic wand and change your smile, what would you want to look like? _____

What concerns, if any, do you have about today's visit? _____

By what name may we call you? _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient Signature

Date