
David Cormier, D.D.S.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____ have received a copy of this office's Notice of
Privacy Practices.

{Please Print Name}

{Signature}

{Date}

I authorize the following persons to have access to my protected health

information: _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but
acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

DAVID C. CORMIER, D.D.S.
HEALTH HISTORY

Patient Name: _____ Soc. Sec. No. _____

Phone _____ Birth Date _____ Age _____

I. Circle Appropriate Answer (leave blank if you do not understand question): _____

1. Yes No Is your general health good?
2. Yes No Has there been a change in your health within the last year?
3. Yes No Have you been hospitalized or had a serious illness in the last three years?
Why? _____
4. Yes No Are you being treated by a physician now? For What? _____
Date of last Medical Exam? _____
Physician's name _____ Address _____
5. Yes No Have you had problems with prior dental treatment? Telephone # _____
6. Yes No Are you in pain now?

II. Have you experienced? _____

- | | | | | |
|------------|---|----|--------|------------------------|
| 7. Yes No | Chest pain (angina)? | 18 | Yes No | Dizziness? |
| 8. Yes No | Swollen ankles? | 19 | Yes No | Ringin ears? |
| 9. Yes No | Shortness of breath? | 20 | Yes No | Headaches? |
| 10. Yes No | Recent weight loss, fever, night sweats | 21 | Yes No | Fainting spells? |
| 11. Yes No | Persistent cough, coughing up blood? | 22 | Yes No | Blurred vision? |
| 12. Yes No | Bleeding problems, bruising easily? | 23 | Yes No | Seizures, epilepsy? |
| 13. Yes No | Sinus problems? | 24 | Yes No | Excessivethirst? |
| 14. Yes No | Difficulty swallowing? | 25 | Yes No | Frequenturination? |
| 15. Yes No | Diarrhea, constipation, blood in stool? | 26 | Yes No | Dry mouth? |
| 16. Yes No | Frequent vomiting? | 27 | Yes No | Jaundice? |
| 17. Yes No | Difficulty urinating, blood in urine? | 28 | Yes No | Joint pain, stiffness? |

III. Do you have or have had?

- | | | | | |
|------------|---|-----|--------|--------------------------------------|
| 29. Yes No | Heart disease? | 40. | Yes No | AIDS, ARC, HIV infection? |
| 30. Yes No | Heart attack, heart defects? | 41. | Yes No | Tumors, cancer? |
| 31. Yes No | Heart murmurs, mitral valve prolapse? | 42. | Yes No | Arthritis, rheumatism? |
| 32. Yes No | Rheumatic fever? | 43. | Yes No | Eye disease? |
| 33. Yes No | Stroke, hardening of arteries? | 44. | Yes No | Skin diseases? |
| 34. Yes No | High blood pressure? | 45. | Yes No | Anemia, blood disease? |
| 35. Yes No | TB, emphysema, other lung diseases? | 46. | Yes No | VD (syphilis, gonorrhea, chlamydia)? |
| 36. Yes No | Hepatitis, other liver disease, jaundice? | 47. | Yes No | Herpes? |
| 37. Yes No | Stomach problems. ulcers? | 48. | Yes No | Kidney, bladder disease? |
| 38. Yes No | ALIERGIES: to drugs, foods, medications/others? | 49. | Yes No | Thyroid, adrenal glands? |
| 39. Yes No | Family history of diabetes, heart problems, tumors? | 50. | Yes No | Diabetes? |

IV. Do you have or have you had? _____

- | | | | | |
|------------|-------------------------|-----|--------|---------------------|
| 51. Yes No | Psychiatric care? | 56. | Yes No | Hospitalization? |
| 52. Yes No | Radiation treatments? | 57. | Yes No | Blood transfusions? |
| 53. Yes No | Chemotherapy? | 59. | Yes No | Surgeries |
| 54. Yes No | Prosthetic heart valve? | 60. | Yes No | Pacemaker? |
| 55. Yes No | Artificial joint? | 60. | Yes No | Contact lenses? |

V. Do you use? _____

- | | | | | |
|------------|------------------------------------|-----|--------|----------------------|
| 61. Yes No | Recreational drugs? | 63. | Yes No | Tobacco in any form? |
| 62. Yes No | Drugs, medicines, (incl. Aspirin)? | 64. | Yes No | Alcohol? |

Please list _____

VI. Women only: _____

- | | | | | |
|------------|--|-----|--------|-----------------------------|
| 65. Yes No | Are you or could you be pregnant or nursing? | 66. | Yes No | Taking birth control pills? |
|------------|--|-----|--------|-----------------------------|

VII. All Patients: _____

67. Yes No Do you nave or nave you nad any orner diseases or medical problems NOT listed on this form?
If so, please explain: _____

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any changes in my health and/or medication.

Patient's signature _____ Date _____

