PATIENT MEDICAL HISTORY

Patient's Name:

For Office Use Only
ID:

Address: | Today's Date: | Date of Last Visit: | Date of Med. History:

City State Zip: | Email:

Home Phone: | Work Phone: | Cell Phone: | Birth Date: | Social Security No.: | Marital Status:

Primary Dental Guarantor: | Home Phone: | Work Phone: | Cell Phone:

Secondary Dental Guarantor: | Home Phone: | Work Phone: | Cell Phone:

Physician Name: | Physician Phone:

Pharmacy: | Pharmacy Phone:

For Office Use Only
Medical Alerts:

Sex:

If female please answer the following:

Y	N	
☐	☐	Are you taking Birth Control Pills?
☐	☐	Are you pregnant? If Yes, # of weeks ☐
☐	☐	Are you nursing?

Please answer the following:

Y	N	
☐	☐	Do you smoke or use tobacco?

Height:

For Office Use Only
BP Heart Rate:

Weight:

Y	N	Conditions
☐	☐	Abnormal Bleeding
☐	☐	Alcohol Abuse
☐	☐	Allergies
☐	☐	Anemia
☐	☐	Angina Pectoris
☐	☐	Arthritis
☐	☐	Artificial Bones
☐	☐	Artificial Heart Valve
☐	☐	Asthma
☐	☐	Blood Transfusion
☐	☐	Cancer- Chemotherapy
☐	☐	Colitis
☐	☐	Congenital Heart Defect
☐	☐	Cosmetic Surgery
☐	☐	Diabetes
☐	☐	Difficulty Breathing
☐	☐	Drug Abuse
☐	☐	Emphysema
☐	☐	Epilepsy
☐	☐	Fainting Spells
☐	☐	Fever Blisters
☐	☐	Frequent Headaches

Y	N	Conditions
☐	☐	Glaucoma
☐	☐	Hay Fever
☐	☐	Heart Attack
☐	☐	Heart Surgery
☐	☐	Hemophilia
☐	☐	Hepatitis A
☐	☐	Hepatitis B
☐	☐	High Blood Pressure
☐	☐	HIV+ AIDS
☐	☐	Kidney Problems
☐	☐	Liver Disease
☐	☐	Low Blood Pressure
☐	☐	Mitral Valve Prolapse
☐	☐	Pace Maker
☐	☐	Pneumocystitis
☐	☐	Psychiatric Problems
☐	☐	Radiation Therapy
☐	☐	Rheumatic Fever
☐	☐	Seizures
☐	☐	Shingles
☐	☐	Sickle Cell Disease
☐	☐	Sinus Problems

Y	N	Conditions
☐	☐	Stroke
☐	☐	Thyroid Problems
☐	☐	Tuberculosis
☐	☐	Ulcers
☐	☐	Venereal Disease
☐	☐	Yellow Jaundice

Y	N	Allergies
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Dental Anesthetics
☐	☐	Erythromycin
☐	☐	Jewelry
☐	☐	Latex
☐	☐	Metals
☐	☐	Penicillin
☐	☐	Tetracycline

Other

_____

_____

_____

Medications:

Y N

☐ ☐ **Is there any disease, condition, or problem that you think this office should know about that is not covered above? If yes, please describe below...**

Notes:

Signature: _____ **Date:** _____

(If Under 18, Parent or Guardian Signature Required)

Shakil A. Virjee D.M.D.
1533 Second Avenue
Watervliet, NY 12189
(518) 274-3424

Notice Of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 196 ("HIPPA"), 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 options such as quality assessments and physicians certifications.

I have received, read and understand 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 it's 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 healthcare options. 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: _____

Shakil A. Virjee, D.M.D., P.C.

Missed Appointment Policy

Our goal is to provide quality individualized dental care in a timely manner. Missed appointments, late shows and cancellations inconvenience those individuals who need access to dental care. We would like to remind you of our policy regarding missed appointments.

Cancellation of an Appointment
In order to be respectful of the dental needs of other patients, please be courteous and call Dr. Virjee's office promptly if you are unable to show up for an appointment. This time will be reallocated to someone who is in need of treatment. If it is necessary to cancel your scheduled appointment, we require that you call at least 24 hours in advance. Appointments are in high demand, and your early cancellation will allow another patient access to timely medical care.

How to Cancel Your Appointment
To cancel your appointment, please call 518-274-3424. If you do not reach the receptionist, you may leave a detailed message on our voice mail. If you would like to reschedule your appointment, please leave your name and phone number. We will return your call promptly.

Late Cancellations: A cancellation is considered to be late when the appointment is cancelled without a 24 hour advance notice. Cancelling an appointment during a courtesy call is considered a late cancellation.

Missed Appointment Policy: A missed appointment is a patient who does not show up for an appointment without cancelling it. A failure to be present at the time of a scheduled appointment will be recorded in the patient's chart as a missed appointment. This includes arriving 15 minutes after your scheduled appointment.

The first time there is a missed appointment, late cancellation, or cancellation without a reasonable excuse there will be no charge to the patient. A 2nd occurrence will result in a fee of the visit. The 3rd occurrence will be the fee of the visit and the patient may be discharged from the practice.

Shakil A. Virjee, D.M.D., P.C.

Cancellation & Missed Appointment Agreement

I understand that I will be charged for any appointments missed or not canceled prior to 24 hours of my scheduled appointment times. I understand that the fee is $75.00 for 45 minute appointments and $150 for anything over 1 hour and no part of this charge is covered by my insurance or EAP program.

By signing this agreement, I commit to paying any charges associated with my appointments (or children's appointments) when I miss an appointment or fail to cancel prior to 24 hours.

ALTHOUGH I MAY RECEIVE A COURTESY CALL THE DAY BEFORE THE APPOINTMENT AS A REMINDER, LACK OF A COURTESY CALL DOES NOT RELIEVE ME OF THE OBLIGATION OF MY APPOINTMENT OR GIVING 24 HOUR NOTICE. FURTHERMORE, IF I CANCEL WHEN THE COURTESY CALL IS MADE, I WILL STILL BE RESPONSIBLE FOR ANY PAYMENTS IF I HAVE NOT CANCELLED PRIOR TO 24 HOURS OF MY APPOINTMENT TIME.

Signature Date