
**Pamela Maragliano-Muniz, DMD**
20 Central Street, Suite 111
Salem, MA 01970
(P) 978.741.1640
(F) 978-741-0024
**www.SalemDentalArtsMA.com**

## PATIENT INFORMATION

**Patient's Name** _____ Birthdate _____

Who referred you to this office _____ Social Security # _____Today's Date _____

Address _____ City _____ ST_____ ZIP _____

Home Phone _____ Work Phone_____ Ext _____

Cell Phone _____ E-Mail _____

Employer_____ City _____ Occupation _____

Name of Parent /Partner/ Spouse / Guardian _____ Birthdate _____
(circle one) Social Security # _____

Address if different _____ City_____ST _____ZIP_____

Home Phone_____ Work Phone _____ Ext_____

Employer _____City _____ Occupation _____

**In case of emergency, whom shall we notify?**

Name _____Relationship_____ Phone _____

**PRIMARY DENTAL INSURANCE**

EMPLOYEE NAME_____

INS CO NAME _____

INSURANCE PHONE_____

GROUP / POLICY # _____

SUBSCRIBER ID #_____

SUBSCRIBER BIRTHDATE _____

**SECONDARY DENTAL INSURANCE**

EMPLOYEE NAME _____

INS CO NAME _____

INSURANCE PHONE _____

GROUP / POLICY #_____

SUBSCRIBER ID # _____

SUBSCRIBER BIRTHDATE _____

**Patient Acknowledgments**:

- I understand that all charges incurred are **payable in full at the time of service**.
- I consent to the taking of radiographs and/or photographs before and during treatment for diagnostic purposes and for the use by the same dentist in scientific papers or demonstrations.
- I consent to the publication of my photos released to Dr. Maragliano-Muniz by any other healthcare providers.
- I certify that I have read (or had read to me), understand and agree to the contents of this form.

I have read the above: Signature _____ Date _____
Parent or Guardian if a minor

**Pamela Maragliano-Muniz, DMD**
20 Central Street, Suite 111
Salem, MA 01970
(P) 978.741.1640
(F) 978-741-0024
**www.SalemDentalArtsMA.com**

# MEDICAL HISTORY FORM

**PATIENT'S NAME: _____ DATE OF BIRTH: _____**

**ADDRESS:** _____

**CITY:** _____ **STATE:** _____ **ZIP CODE:** _____

**BILLING ADDRESS (if different):** _____

**E-MAIL ADDRESS:** _____

**CELL:** _____ **HOME/ALT PHONE:** _____

**EMERGENCY CONTACT:** _____ **RELATIONSHIP:** _____

**EMERGENCY CONTACT PHONE:** _____

**REFERRED BY:** _____

**PHYSICIAN'S NAME:** _____ **PHONE:** _____

**PHYSICIAN'S ADDRESS:** _____

**DATE OF LAST PHYSICAL:** _____

**Are you under the care of a recent or ongoing medical condition?** _____

**If yes, please explain:** _____

**Have you ever been hospitalized or had a major operation within the last year?** _____

**If yes, please explain:** _____

**Have you had any serious medical issues associated with any dental treatment?** _____

**If yes, please explain:** _____

**Have you been advised to take antibiotics before a dental appointment?** _____

**If yes, please explain:** _____

***PLEASE CHECK IF YOU HAVE HAD or HAVE ANY OF THE FOLLOWING CONDITIONS:***

__ **AIDS/HIV POSITIVE**
__ **ALZHEIMER'S DISEASE**
__ **ANAPHYLAXIS**
__ **ANEMIA**
__ **ARTHRITIS**
__ **ARTIFICIAL HEART VALVE**
__ **ARTIFICIAL JOINT**
__ **ASTHMA**
__ **BLOOD DISEASE**
__ **BLOOD TRANSFUSION**
__ **BREATHING PROBLEMS**
__ **BRUISE EASILY**
__ **CANCER**
__ **CHEMOTHERAPY**
__ **CHEST PAINS**
__ **COLD SORES**
__ **CONGENIAL HEART D.**
__ **DIABETES**
__ **DRUG ADDICTION**
__ **EMPHYSEMA**
__ **EPILEPSY or SEIZURES**
__ **EXCESSIVE THIRST**
__ **FAINTING SPELLS/DIZZINESS**
__ **FREQUENT COUGH**
__ **FREQUENT HEADACHES**
__ **GLAUCOMA**
__ **HAY FEVER**
__ **HEART ATTACK/FAILURE**
__ **HEART MURMUR**
__ **HEART PACEMAKER**
__ **HEART TROUBLE//DISEASE**
__ **HEMOPHILIA**
__ **HEPATITIS A**
__ **HEPATITIS B or C**
__ **HIGH BLOOD PRESSURE**
__ **HIGH CHOLESTEROL**
__ **HYPOGLYCEMIA**
__ **KIDNEY PROBLEMS**
__ **LEUKEMIA**
__ **LIVER DISEASE**
__ **LEUKEMIA**
__ **LIVER DISEASE**
__ **LOW BLOOD PRESSURE**
__ **LUNG DISEASE**
__ **M.VALVE PROLAPSE**
__ **OSTEOPOROSIS:SEE BELOW**
__ **HISTORY OF TAKING BISPHOSPHONATES IV/ORAL**
__ **PSYCHIATRIC CARE**
__ **RADIATION TREATMENTS**
__ **RECENT WEIGHT LOSS**
__ **RENAL DIALYSIS**
__ **RHEUMATIC FEVER**
__ **RHEUMATISM**
__ **SCARLET FEVER**
__ **SHINGLES**
__ **SINUS TROUBLE**
__ **STOMACH /INTESTINAL D.**
__ **STROKE**
__ **THYROID DISEASE**
__ **TUBERCULOSIS**
__ **TUMORS or GROWTHS**
__ **ULCERS**
__ **OTHER: FILL IN BELOW**
_____
_____

**Do you have any disease, condition or medical problem not listed you feel we should know?**

**Please explain:**

_____
_____
_____

**CURRENT MEDICATIONS and DOSAGE INCLUDING OVER THE COUNTER AND HERBAL:**

**ALLERGIES: Are you allergic to any drugs, food, environment, animals? Please explain:**

**NOTES SECTION FOR SALEM DENTAL ARTS:**

# DENTAL HISTORY

**What is your chief complaint concerning your mouth or teeth?**

_____

_____

**Have you had any serious trouble associated with any previous dental treatment?** _____

***If yes, please explain:*** _____

**Have you had any undesirable reaction to local or general anesthetics?** _____

***If yes, please explain:*** _____

**Are you dissatisfied with the appearance of your teeth?** _____

***If yes, please explain:*** _____

**Do you clench or grind your teeth?** _____

***If yes, please explain:*** _____

**Do you have pain in the face, cheeks, jaw, throat or temples?** _____

***If yes, please explain:*** _____

**Are your teeth sensitive to cold, hot or sweets?** _____

***If yes, please explain:*** _____

**Do you have bleeding gums?** _____

***If yes, please explain:*** _____

**Do you gag easily?** _____

***If yes, please explain:*** _____

**Is there any other information you would like to share with Salem Dental Arts concerning your care? Please explain:** _____

_____

**To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.**

***Signature of Patient, Parent or Guardian:*** _____ ***Date:*** _____

***Reviewed by Signature:*** _____ ***Date:*** _____

**Pamela Maragliano-Muniz, DMD**
20 Central Street, Suite 111
Salem, MA 01970
(P) 978.741.1640
(F) 978-741-0024
**www.SalemDentalArtsMA.com**

# NOTICE OF PRIVACY PRACTICE SUMMARY

This summary discloses how Healthcare Information about you may be used by Dr. Pamela Maragliano-Muniz or any healthcare provider at Salem Dental Arts. A full notice of your privacy rights has been provided to you.

**Treatment, Payment, Operations.** We may use health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive.

**Uses and Disclosures for Appointment Reminders.** We may use and disclose your Healthcare information to contact you as a reminder that you have an appointment at the office. If you request that such communications be made confidentially, please contact our office in writing. We will accommodate all reasonable requests.

**Authorization for Use and Disclosure.** We will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so.

**Public health, research, health and safety, government, works compensation.** We may disclose your information for public health activities, research, health and safety, governmental function, and in order to comply with workers compensation laws and regulations.

**Rights.** You have a right to inspect and copy information used to make decisions about your care, to request an amendment of the information, to an accounting of disclosures, to request communication with you by alternate means, to request restrictions on the information we use, and to revoke your authorization for release of information.

**Complaints.** You may complain to the Privacy Information Director at 206.223.0033 or to the Department of Health and Human resources if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint.

**Organization duties.** We must maintain the privacy of protected health information, provide you with notice of our legal duties and privacy practice with respect to your health information, abide by the terms of the notice, notify you if we are unable to agree to the requested restriction on how your information is used or disclosed, accommodate reasonable requests you may make to communicate with health information by alternative means or by alternative locations, and obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted under law.

**Questions.** If you have any questions, please contact the Privacy Officer at 206.223.0033.

"I acknowledge that I have received the full Privacy Notice."

| _____ | _____ | _____ |
|---|---|---|
| Name (print) | Signature | Date |
| _____ | _____ | _____ |
| Witness | Signature | Date |