## Aspire Implant Dentistry Center Anthony M. Di Cesare, DDS

147 Rt. 70, Ste. 10 Toms River, NJ 08755 732-994-1061

Ton	ns Rive	er, NJ 08755	www.aspiresmiles.com					
Nan	ne:	Birthda	te:SS#					
		dress:						
			Zip Code:					
City: Stat Telephone: Home: Cell			Work:					
Email Address:			Spouse Name:					
		Occupation:						
		Address:						
			?					
			Phone #					
		t seen?						
		completing this form for another person,	what is your relationship?					
			The second secon					
		ng questions mark yes or no, whichever applies. Your a	nswers are for our records only and are confidential.					
Yes	18-36645	Ana way in good backle?						
		Are you in good health?						
		Has there been any change in your heal						
		Are you now under the care of a physici	an?					
		If so, what condition is being treated?						
		Name and Address of your physician:						
		Have you had a serious illness or operation?						
		If so, what was the problem?						
		Are you currently taking any medication	s or non presctiption medications?					
		If so, what prescriptions are you taking?						
		Over the counter?						
		Herbal or Natural?						
		Are you alchohol or drug dependent?						
		If so, have you received treatment?						
		If so, what interest do you have in quitting? $\Box$ Ve	ry interested   Somewhat   Not interested					
		Do you wear contact lenses?						
		Have you had orthopedic total joint (hip	,knee,elbow,shoulder) replacement?					
		If so, date of operation						
		Have you had any complications or difficulties with prosthetic joint?						
		Has a physician or dentist recommended that you take an antibiotic prior to dental work?						
		(Women only) Are you pregnant?	Market Control and					
	- 🗆	Nursing?						
П	П	Taking hirth con	nl nills?					

	HGIES:									
Yes	Local Anesthetics Aspirin Penicillin		Yes	Latex todine Hay Fever/Seasonal	Are you cu YES	errently taking a daily aspirin? or NO				
		oina nille	Ħ							
	Barbiturates, sedatives, sleej	oing pins		Food						
	Sulfa drugs			Other	-					
	Codeine or other narcotics				*					
Please	(X) if you have or had any of the	he followi	ing diseas	es or problems.						
	(0,000,000,000,000,000,000,000,000,000,	Yes	·	5.00 30 - 100 00 Print   Print   100 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Yes	•				
Yes	at		Chest pai	n upon exertion	Ü	Neurological disorders				
	Abnormal bleeding	H	Chronic p			If yes, specify:				
	Anemia				П	Respiratory problems				
	AIDS or HIV infection	H	Persisten			If yes, specify below:				
	Arthritis $\square$		Disease, drug, or radiation							
П	Rheumatoid arthritis		induced immunosuppression			☐ Emphysema				
n	Asthma			If yes, specify below:		Bronchitis, etc.				
币	Blood transfusion		Type	I (Insulin dependent)		Severe headaches				
	If yes, date		Type			Severe or rapid weight loss				
П	Cancer/chemotherapy/radiatio		Eating Di	sorder. If yes, specify	[] .	Sexually transmitted disease				
	treatment	$\overline{\Box}$	Dry mout	h		Sinus trouble				
	Cardiovascular disease	H	Epilepsy		П	Sleep disorder				
		H		pells or seizures	ñ	Sores or ulcers in the mouth				
	If yes, specify below	吕	G.E. reflu		吕	Stroke				
	Angina Angina		Glaucom		片	Systemic lupus erythematosus				
	☐ Arteriosclerosis	님			닏.					
	Artificial heart valves		Hemophi		닏	Thyroid problems				
	Coronary insufficiency			jaundice or liver disease		Tuberculosis .				
	Coronary occlusion		Recurren	tinfections		Ulcers				
	Damaged heart valves		Indicate t	ype of infection	——— <b></b>	Excessive unnation				
	Heart attack		Kidney pr	oblems		Do you have any disease, condition,				
	Heart murmur		Low bloo	d pressure		or problem not listed above that you				
	High blood pressure		Mental he	ealth disorders		think I should know about?				
	Inbom heart defects		If yes, sp	ecify:		Please explain:				
	Mitral valve prolapse	П	Malnutriti	on						
	Pacemaker	H	Migraines							
	Rheumatic heart disease	Ħ.	Night Sw							
	Aneumatic neart disease	ر ا	, ingine ciri							
have	tify that I have read and understate been answered to my satisfactions that I may have made in the	on. I will n	ot hold my	dentist, or any other mem						
		Signature	of Patient	/Legal Guardian	Date					
	COMPLETION BY DENTIST ments on patient interview cond	eming h	eaith histo	ry:						
Dental	Dental management considerations:									
						7				
		Signatur	e of Denti	st ·	Date					

## Anthony M. Di Cesare, DDS 147 Rt. 70. Ste. 10. Toms River, NJ 08755

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

\*\*You may refuse to sign this acknowledgement\*\*

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain acknowledgement.

I have received a copy of the Notice of HIPAA Privacy for the Dental Practice (Please Sign Name) (Please Print Name) (Date) Designation of Certain Relatives, Close Friends and Other Caregivers: I agree that the practice may disclose my health information to a family member, close personal friend or other caregiver since such person is involved with my healthcare or payment relating to my healthcare. In that case, the Dental Practice will disclose only information that is directly relevant to the person's involvement with my healthcare or payment relating to my healthcare. I wish to be contacted in the following manner. (check all that apply.) Telephone, Written & Fax Communication Home/Cell phone number: Written Communication: Ok to leave message with detailed information Ok to mail to my home address Leave message with call back number only Ok to mail to my work address Work phone number: Fax Communication: Ok to fax to this number\_\_\_\_\_ Ok to leave message with detailed information Leave message with call back number only I designate the following persons listed below as persons involved with my healthcare or payment relating to my healthcare for the purpose of the practice making the limited disclosures described above. I understand that I am not required to list anyone. I also understand that I may change this list at any time in writing. Print Name: Print Name: The following person(s) are not authorized to receive my Patient Health Information: Print Name: Print Name:

The privacy rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of and requests for patient information to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses and disclosures made pursuant to the authorizations requested by the patient/parent/guardian. Uses and disclosures for treatment, payment and healthcare operations may be permitted without prior consent.



## **RECORDS/INSURANCE RELEASE**

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my dependents during the period of such dental care to third party payees and/or health practitioners.

SIGNATURE	DATE
	spire does not participate in my dental insurancer all costs of dental treatment rendered.
SIGNATURE	DATE

e



Dear Doctor:								
Re:	DOB:							
Your patient has been referred to me for dental treatment. At the next visit I will have completed the radiographic and clinical examination necessary for a thorough dental diagnosis and will be developing treatment plan.								
As you are aware new scientific evidence indicates possible links between periodontal disease and other systemic diseases such as diabetes, heart and respiratory disease. Please forward any information regarding your patient's physical condition that you feel would be useful to me.								
Sincerely,								
Anthony M. Di Cesare, DDS								
To your knowledge does the patient have any of the following:								
Heart Disease Abnormal Blood Pressure Bleeding problems or is taking blood thinners Respiratory Disease Endocrine Disturbances Serious personality disorders Chronic digestive disturbances History of bisphosphonate usage  Does this patient need prophylactic pre-medication for lf yes, what are your recommendations for medication	r dental procedures? YES or NO							
Tryes, what are your recommendations for medication								
In case I becomes necessary to administer an anesthet for: Local AnesthesiaRemarks:								
Physician Signature:	Date							
*I authorize the release of any and all information re	lative to my care							
Patient Signature:	Date							

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