Richard B. Lipshultz, D.M.D.
Michelle L. Lipshultz, D.M.D.

586 Knickerbocker Road
Cresskill, New Jersey 07626
Telephone (201)568-2823
Fax (201)568-0665
drslipshultz@gmail.com

Welcome!

Please print and complete the forms, and bring with you to your appointment.
If you must reschedule this appointment, please give us at least 24 hour notice.
If you have any additional questions, please contact our office.

We look forward to meeting you.

Thank you,
Drs. Lipshultz and Staff

Health History Form

ADA American Dental Association®
America's leading advocate for oral health

Email: Today's Date:

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: *Last* *First* *Middle*
Home Phone: *Include area code* ( )
Business/Cell Phone: *Include area code* ( )

Address: *Mailing address*
City: State: Zip:

Occupation:
Height: Weight: Date of Birth: Sex: M F

SS# or Patient ID: Emergency Contact:
Relationship: Home Phone: *Include area code* ( ) Cell Phone: *Include area code* ( )

If you are completing this form for another person, what is your relationship to that person?

Your Name *Relationship*

Do you have any of the following diseases or problems: *(Check DK if you Don't Know the answer to the the question)*	**Yes**	**No**	**DK**
Active Tuberculosis	☐	☐	☐
Persistent cough greater than a 3 week duration	☐	☐	☐
Cough that produces blood	☐	☐	☐
Been exposed to anyone with tuberculosis	☐	☐	☐

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Dental Information *For the following questions, please mark (X) your responses to the following questions.*

	Yes	**No**	**DK**
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐
Do you drink bottled or filtered water?	☐	☐	☐
If yes, how often? *Circle one:* DAILY / WEEKLY / OCCASIONALLY			
Are you currently experiencing dental pain or discomfort?	☐	☐	☐

	Yes	**No**	**DK**
Do you have earaches or neck pains?	☐	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Do you brux or grind your teeth?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Do you participate in active recreational activities?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐

Date of your last dental exam:
What was done at that time?

Date of last dental x-rays:

What is the reason for your dental visit today?

How do you feel about your smile?

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

	Yes	**No**	**DK**
Are you now under the care of a physician?	☐	☐	☐

Physician Name: Phone: *Include area code* ( )

Address/City/State/Zip:

Are you in good health?	☐	☐	☐
Has there been any change in your general health within the past year?	☐	☐	☐

If yes, what condition is being treated?

Date of last physical exam:

	Yes	**No**	**DK**
Have you had a serious illness, operation or been hospitalized **in the past 5 years?**	☐	☐	☐

If yes, what was the illness or problem?

Are you taking or have you recently taken any prescription **or over the counter medicine(s)?**	☐	☐	☐

If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements:

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Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

(Check DK if you Don't Know the answer to the question)

Do you wear contact lenses? ☐ Yes ☐ No ☐ DK

Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? ☐ Yes ☐ No ☐ DK

Date: _____ If yes, have you had any complications? _____

Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax®, Actonel®, Atelvia, Boniva®, Reclast, Prolia) for osteoporosis or Paget's disease? ☐ Yes ☐ No ☐ DK

Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia®, Zometa®, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? ☐ Yes ☐ No ☐ DK

Date Treatment began: _____

Do you use controlled substances (drugs)? ☐ Yes ☐ No ☐ DK

Do you use tobacco (smoking, snuff, chew, bidis)? ☐ Yes ☐ No ☐ DK

If so, how interested are you in stopping?
Circle one: VERY / SOMEWHAT / NOT INTERESTED

Do you drink alcoholic beverages? ☐ Yes ☐ No ☐ DK

If yes, how much alcohol did you drink in the last 24 hours? _____

If yes, how much do you typically drink i n a week? _____

WOMEN ONLY Are you:

Pregnant? ☐ Yes ☐ No ☐ DK

Number of weeks: _____

Taking birth control pills or hormonal replacement? ☐ Yes ☐ No ☐ DK

Nursing? ☐ Yes ☐ No ☐ DK

Allergies. Are you allergic to or have you had a reaction to:
To all **yes** responses, specify type of reaction.

	Yes	No	DK
Local anesthetics _____	☐	☐	☐
Aspirin _____	☐	☐	☐
Penicillin or other antibiotics _____	☐	☐	☐
Barbiturates, sedatives, or sleeping pills _____	☐	☐	☐
Sulfa drugs _____	☐	☐	☐
Codeine or other narcotics _____	☐	☐	☐
Metals _____	☐	☐	☐
Latex (rubber) _____	☐	☐	☐
Iodine _____	☐	☐	☐
Hay fever/seasonal _____	☐	☐	☐
Animals _____	☐	☐	☐
Food _____	☐	☐	☐
Other _____	☐	☐	☐

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No	DK
Artificial (prosthetic) heart valve	☐	☐	☐
Previous infective endocarditis	☐	☐	☐
Damaged valves in transplanted heart	☐	☐	☐
Congenital heart disease (CHD)			
Unrepaired, cyanotic CHD	☐	☐	☐
Repaired (completely) in last 6 months	☐	☐	☐
Repaired CHD with residual defects	☐	☐	☐

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

	Yes	No	DK
Cardiovascular disease	☐	☐	☐
Angina	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Congestive heart failure	☐	☐	☐
Damaged heart valves	☐	☐	☐
Heart attack	☐	☐	☐
Heart murmur	☐	☐	☐
Low blood pressure	☐	☐	☐
High blood pressure	☐	☐	☐
Other congenital heart defects	☐	☐	☐
Mitral valve prolapse	☐	☐	☐
Pacemaker	☐	☐	☐
Rheumatic fever	☐	☐	☐
Rheumatic heart disease	☐	☐	☐
Abnormal bleeding	☐	☐	☐
Anemia	☐	☐	☐
Blood transfusion	☐	☐	☐
If yes, date: _____			
Hemophilia	☐	☐	☐
AIDS or HIV infection	☐	☐	☐
Arthritis	☐	☐	☐

	Yes	No	DK
Autoimmune disease	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Systemic lupus erythematosus	☐	☐	☐
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐
Tuberculosis	☐	☐	☐
Cancer/Chemotherapy/ Radiation Treatment	☐	☐	☐
Chest pain upon exertion	☐	☐	☐
Chronic pain	☐	☐	☐
Diabetes Type I or II	☐	☐	☐
Eating disorder	☐	☐	☐
Malnutrition	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
G.E. Reflux/persistent heartburn	☐	☐	☐
Ulcers	☐	☐	☐
Thyroid problems	☐	☐	☐
Stroke	☐	☐	☐

	Yes	No	DK
Glaucoma	☐	☐	☐
Hepatitis, jaundice or liver disease	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Neurological disorders	☐	☐	☐
If yes, specify: _____			
Sleep disorder	☐	☐	☐
Do you snore?	☐	☐	☐
Mental health disorders	☐	☐	☐
Specify: _____			
Recurrent Infections	☐	☐	☐
Type of infection: _____			
Kidney problems	☐	☐	☐
Night sweats	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistent swollen glands in neck	☐	☐	☐
Severe headaches/ migraines	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
Excessive urination	☐	☐	☐

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ☐ Yes ☐ No ☐ DK

Name of physician or dentist making recommendation:

Phone: *Include area code*
( )

Do you have any disease, condition, or problem not listed above that you think I should know about? ☐ Yes ☐ No ☐ DK
Please explain:

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: Date:

Signature of Dentist: Date:

FOR COMPLETION BY DENTIST

Comments:

Richard B. Lipshultz DMD Michelle L. Lipshultz DMD

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____Email: _____

SECTION B: TO THE PATIENT — PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent **:** By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.
We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.
You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Dr. Richard Lipshultz 586 Knickerbocker Rd. Cresskill, NJ 07626
Telephone: (201) 568-2823 Fax: (201)568-0665 Email Address: drslipshultz@gmail.com

Right to Revoke : You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.
SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature:_____ Date:_____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative'sName:_____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Include completed Consent in the patient's chart .

DRS. LIPSHULTZ 586 KNICKERBOCKER RD. CRESSKILL, NEW JERSEY 07626

Acknowledgement of Receipt of Notice of Privacy Practices

You May Refuse to Sign This Acknowledgment

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

Print Name:_____

Signature:_____

Date:_____

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)

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Michelle L. Lipshultz D.M.D.
586 Knickerbocker Road
Cresskill, New Jersey 07626
(201)568-2823 Fax (201)568-0665

Patient Name: _____

Preferred Method ( )

Cell Phone Number: _____ _____

Work Phone Number:_____ _____

Home Phone Number: _____ _____

Email Address: _____ _____

I give my permission to be contacted at the above phone numbers or email regarding my dental care: to include, but not limited to, scheduled and unscheduled dental appointments.

Patient Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

Richard Lipshultz DMD
Michelle Lipshultz DMD
586 Knickerbocker Rd.
Cresskill, NJ 07626

If you have Dental Insurance, please print out and complete this form for your appointment.

Patient Name: _____

Dental Insurance Company: _____

Subscriber Name: _____

Subscriber Birthdate: _____

Group Number: _____

Subscriber ID Number: _____

Subscriber's Relationship to Patient: _____

Is patient covered by additional dental Insurance? Yes No

Additional Dental Insurance Company: _____

Subscriber Name: _____

Subscriber Birthdate: _____

Subscriber ID Number: _____

Group Number: _____

Subscriber's Relationship to Patient: _____

ASSIGNMENT AND RELEASE:

I certify that I, and/or my dependent(s) have insurance coverage with_____
Name of Insurance Company(ies)

and assign directly to Dr.Richard Lipshultz or Dr. Michelle Lipshultz all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorized the use of my signature on all insurance submissions.

The above-named dentists may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payments for services and determining insurance benefits or the benefits payable for related services.

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

Printed Name of Patient,Parent or Guardain_____

Relationship to Patient:_____

Patient Advisory and Acknowledgment Receiving Routine Dental Treatment During the COVID-19 Pandemic

Dear Patient:

You have come to our office today for a routine dental evaluation and/or treatment that will be done during the COVID-19 pandemic. Please be advised of the following:

While our office complies with the State Health Department and the Centers for Disease Control and Prevention infection control guidelines to prevent the spread of COVID-19 virus, we cannot make any guarantees. Our staff are symptom-free and to the best of their knowledge have not been exposed to the virus. However, since we are a place of public accommodation, other persons (including other patients) could be infected with or without their knowledge.

In order to reduce the risk of spreading COVID-19, we have asked you a number of "screening" questions below. For the safety of our staff, other patients, and yourself, please be truthful and candid in your answers.

_____ _____

PATIENT/RESPONSIBLE PARTY **DATE**

PLEASE ANSWER "YES" OR "NO" WITH YOUR INITITALS, TO THE FOLLOWING QUESTIONS

HAVE YOU BEEN DIAGNOSED POSITIVE FOR THE COVID-19 VIRUS AT ANY TIME? _____YES _____NO

ARE YOU CURRENTLY AWAITING THE RESULTS OF A COVID-19 TEST? _____YES _____NO

HAVE YOU HAD CONTACT WITH SOMEONE WHO WAS DIAGNOSED WITH COVID-19? _____YES _____NO

CURRENTLY OR IN THE PAST 14 DAYS:

HAVE YOU HAD CONTACT WITH SOMEONE EXPOSED TO COVID-19? _____YES _____NO

HAVE YOU HAD CONTACT WITH SOMEONE EXPERIENCING SYMPTOMS OF COVID-19? _____YES _____NO

DO YOU HAVE A FEVER? _____YES _____NO

DO YOU HAVE ANY SYMPTOMS OF A FEVER? DO YOU HAVE CHILLS, SWEATING OR FEEL HOT? _____YES _____NO

DO YOU HAVE A COUGH? _____YES _____NO

DO YOU HAVE SHORTNESS OF BREATH, OR DIFFICULTY BREATHING? _____YES _____NO

DO YOU HAVE CONGESTION, RUNNY OR STUFFED NOSE, OR REDNESS IN YOUR EYES? _____YES _____NO

DO YOU HAVE A SORE THROAT? _____YES _____NO

DO YOU HAVE SNEEZING, WATERY EYES, AND/OR SINUS PAIN/PRESSURE THAT IS UNUSUAL AND NOT RELATED TO SEASONAL ALLERGIES? ----------YES ----------NO

HAVE YOU EXPERIENCED HEADACHES, FATIGUE, MUSCLE OR BODY ACHES, OR WEAKNESS? ----------YES ----------NO

HAVE YOU LOST YOUR SENSE OF TASTE AND/OR SMELL? ----------YES ----------NO

DO YOU HAVE ANY GASTROINTESTINAL SYMPTOMS, NAUSEA, VOMITING, DIARRHEA? ----------YES ----------NO

HAVE YOU EXPERIENCED ANY NEUROLOGICAL SYMPTOMS, INCLUDING CONFUSION? ----------YES ---------NO

WITHIN THE LAST 14 DAYS HAVE YOU TRAVELLED, EITHER WITHIN THE UNITED STATES OR TO ANY FOREIGN COUNTRY? IF SO, WHERE? _____ ----------YES ----------NO

Patient Advisory and Acknowledgment Receiving Urgent Dental Treatment During the COVID-19 Pandemic

Dear Patient:

You have presented to the dental office today because you have an urgent dental condition which must be treated at this time and cannot be postponed until the current COVID-19 RISK period abates.. Please be advised of the following:

While our office complies with the State Health Department and the Centers for Disease Control and Prevention infection control guidelines to prevent the spread of COVID-19 virus, we cannot make any guarantees. Our staff are symptom-free and to the best of their knowledge have not been exposed to the virus. However, since we are a place of public accommodation, other persons (including other patients) could be infected with or without their knowledge.

In order to reduce the risk of spreading COVID-19, we have asked you a number of "screening" questions below. For the safety of our staff, other patients, and yourself, please be truthful and candid in your answers.

_____ _____

PATIENT/RESPONSIBLE PARTY **DATE**

PLEASE ANSWER "YES" OR "NO" WITH YOUR INITITALS, TO THE FOLLOWING QUESTIONS

HAVE YOU BEEN DIAGNOSED POSITIVE FOR THE COVID-19 VIRUS AT ANY TIME? _____YES _____NO

ARE YOU CURRENTLY AWAITING THE RESULTS OF A COVID-19 TEST? _____YES _____NO

HAVE YOU HAD CONTACT WITH SOMEONE WHO WAS DIAGNOSED WITH COVID-19? _____YES _____NO

CURRENTLY OR IN THE PAST 14 DAYS:

HAVE YOU HAD CONTACT WITH SOMEONE EXPOSED TO COVID-19? _____YES _____NO

HAVE YOU HAD CONTACT WITH SOMEONE EXPERIENCING SYMPTOMS OF COVID-19? _____YES _____NO

DO YOU HAVE A FEVER? _____YES _____NO

DO YOU HAVE ANY SYMPTOMS OF A FEVER, OR HAVE CHILLS, SWEATING, OR FEEL HOT? ----------YES ----------NO

DO YOU HAVE A COUGH? _____YES _____NO

DO YOU HAVE SHORTNESS OF BREATH, OR DIFFICULTY BREATHING? _____YES _____NO

DO YOU HAVE CONGESTION, RUNNY OR STUFFED NOSE, OR REDNESS IN YOUR EYES? _____YES _____NO

DO YOU HAVE A SORE THROAT? _____YES _____NO

DO YOU HAVE SNEEZING, WATERY EYES, AND/OR SINUS PAIN/PRESSURE THAT IS UNUSUAL AND NOT RELATED TO SEASONAL ALLERGIES? ----------YES ----------NO

HAVE YOU EXPERIENCED HEADACHES, FATIGUE, MUSCLE OR BODY ACHES, OR WEAKNESS? ----------YES ----------NO

HAVE YOU LOST YOUR SENSE OF TASTE AND/OR SMELL? ----------YES ----------NO

DO YOU HAVE ANY GASTROINTESTINAL SYMPTOMS, NAUSEA, VOMITING, DIARRHEA? ----------YES ----------NO

HAVE YOU EXPERIENCED ANY NEUROLOGICAL SYMPTOMS, INCLUDING CONFUSION? ----------YES ---------NO

WITHIN THE LAST 14 DAYS HAVE YOU TRAVELLED, EITHER WITHIN THE UNITED STATES OR TO ANY FOREIGN COUNTRY? IF SO, WHERE?_____ ----------YES ----------NO