STANLEY E. KACHERSKI, D.D.S., M.S., P.C.
Clove Branch Professional Center
129 Clove Branch Road
Hopewell Junction , New York 12533

PATIENT DENTAL HISTORY:	YES	NO
1. When was your last dental exam?		
2. When was your last full mouth x ray taken?		
3. Have you had trouble from previous dental care?		
4. Do you have pain in your jaw or near your ears?		
5. Do you have any unhealed injuries or inflamed areas in or around your mouth?		
6. Have you experienced any growths or sore spots in your mouth?		
7. Does any part of your mouth hurt when clenched?		
8. Have you ever had Novocaine or other local anesthetic?		
9. Have you ever had Nitrous Oxide (laughing gas) or General Anesthesia?		
10. Any reaction or allergic symptoms to Novocaine, local or general anesthetics?		
11. Any difficult extractions in the past?		
12. Prolonged bleeding following extractions in the past?		
13. Do you gums bleed?		
14. Do you have bad taste in your mouth or mouth odor?		
15. Have you ever had instructions on the care of your gums?		
16. Do you chew on only one side of you mouth? If so why?		
17. Do you habitually clench or grind your teeth during the night or day?		
18. Any part of you mouth sensitive to pressures or irritants (hot, cold, or sweets)?		

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

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I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), 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 operations such as quality assessments and physician certifications.

I have received a copy of your Notice of Privacy Practice containing a more complete description of the use and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy 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 health care operations. I also understand that you are not required to agree to my requested restrictions but if you do' agree then you are bound to abide my such restrictions,

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____