

Williamsville Family Dentistry  
1630 Maple Road  
Williamsville, NY 14221  
(716) 568-CARE(2273)  
www.wfdsmile.com

North Tonawanda Family Dentistry  
301 Meadow Drive  
North Tonawanda, NY 14120  
(716) 692-2273  
www.ntfdsmile.com

---

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

---

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

**TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS**

The most common reason why we use or disclose your health Information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth; prescribing medications and faxing them to be filled; referring you to another doctor or clinic for other health care or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health Information for payment purposes are: asking you about your health or dental care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health Information for health care Operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we will ask you for special written permission.

**USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION**

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- when a state or federal law mandates that certain health information be reported for a specific purpose;
- for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
- disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- disclosure to a medical examiner to identify a dead person or to determine the cause of death; or

- to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- uses or disclosures for health related research;
- uses and disclosures to prevent a serious threat to health or safety;
- uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
- disclosures of de-identified information;
- disclosures relating to worker's compensation programs;
- disclosures of a 'limited data set for research, public health, or health care operations;
- incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- disclosures to 'business associates' who perform health care operations for us and who commit to respect the privacy of your health Information;

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your dental care.

### **APPOINTMENT REMINDERS**

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

### **OTHER USES AND DISCLOSURES**

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours. If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

### **YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION**

The law gives you many rights regarding your health information. You can:

- ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address, fax or email shown at the beginning of this Notice.
- ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using email to your personal email address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or email shown at the beginning of this Notice.
- ask to see or to get photocopies of your health Information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30 day extension of the time for us to

give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax or email shown at the beginning of this Notice.

- ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the Information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong Information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health Information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax or email shown at the beginning of this Notice.
- get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax or email shown at the beginning of this Notice.
- get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax or email shown at the beginning of this Notice.

## **OUR NOTICE OF PRIVACY PRACTICES**

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health Information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our website.

## **COMPLAINTS**

If you think that we have not properly respected the privacy of your health Information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or email shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

## **FOR MORE INFORMATION**

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.

----- tear here -----

## **ACKNOWLEDGEMENT OF RECEIPT**

I acknowledge that I received a copy of the Williamsville and North Tonawanda Family Dentistry Notice of Privacy Practices.

Patient name \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Williamsville Family Dentistry  
1630 Maple Road  
Williamsville, NY 14221  
**(716) 568-CARE(2273)**  
**www.wfdsmile.com**

North Tonawanda Family Dentistry  
301 Meadow Drive  
North Tonawanda, NY 14120  
**(716) 692-2273**  
**www.ntfdsmile.com**

---

**AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION**

---

Patient name \_\_\_\_\_

Patient number \_\_\_\_\_

Patient address \_\_\_\_\_

Patient phone number \_\_\_\_\_

I authorize the professional office of my dentist named above to release health information identifying me [including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services] under the following terms and conditions:

1. Detailed description of the information to be released:
2. To whom may the information be released [name(s) or class(es) of recipients]:
3. The purpose(s) for the release (if the authorization is initiated by the individual, it is permissible to state "at the request of the individual" as the purpose, if desired by the individual):
4. Expiration date or event relating to the individual or purpose for the release:

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office contact person listed at the top of this form.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

[For marketing authorizations, include, as applicable: We will receive direct or indirect remuneration from a third party for disclosing your identifiable health information in accordance with this authorization.]

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Dated \_\_\_\_\_ Patient signature \_\_\_\_\_

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient \_\_\_\_\_ Print Name \_\_\_\_\_

Source of Authority \_\_\_\_\_

## APPOINTMENT AGREEMENT

Welcome to our practice. We are honored that you have selected us for all your dental wants and needs.

As our patient, and to ensure we deliver exceptional dental care, we want to share with you that we are 100% committed to providing timely and quality service to all our patients.

However, we believe that an important aspect of delivering exceptional dental care is our patients commitment to our practice as well.

Therefore, we request that you honor your reserved appointment as scheduled. And should you have to change your appointment for any reason, we ask that you give our practice 48 business hours advance notice. We do need to receive verbal confirmation that the reserved appointment time and date are still acceptable.

Because missed appointments increase the cost of healthcare for everyone, after an appointment is missed in which 48 business hours notice has not been given, you may be required to pay a \$50 reservation fee before reserving your next appointment. The reservation fee of \$50 will then be applied to any treatment rendered, or forfeited if your reserved appointment is missed or cancelled without giving the required 48 business hours advance notice. We appreciate your understanding in this matter.

**ATTENTION - All State Aid Patients: Due to the New York State Medicaid Budget Cuts, guidelines and increased constraints of your insurance plan, the practice may no longer be able to reappoint you for future appointments if you cancel or change your reserved appointment without giving the required 48 business hours advance notice.**

Sincerely,

The Dental Team of Williamsville Family Dentistry and North Tonawanda Family Dentistry

I have read, understand and will honor the practice's Appointment Agreement as listed above.

Patient Signature \_\_\_\_\_ Date: \_\_\_\_\_

## FINANCIAL AGREEMENT FOR WILLIAMSVILLE FAMILY DENTISTRY and NORTH TONAWANDA FAMILY DENTISTRY

This agreement is to inform you of your financial obligation to our practice. We are committed to providing you with the most comprehensive dental care using only the highest quality materials and technology available in the market today. We are also committed to providing you with up-to-date information and educational tools so that you may fully participate in maintaining optimum oral health. This financial agreement is intended to facilitate our ability to provide excellent service to you while minimizing our administrative costs.

All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is an agreement between you, your employer, and the insurance company. Our practice is not a party to that agreement. If payment from your insurance company is not received within 60 days from date of service, you will be expected to pay the balance in full.

As a courtesy to you we will help you process all your insurance claims. You may direct your insurance company to pay your benefits directly to our practice by signing the authorization on the Assignment of Benefits Agreement. In order for our practice to file your insurance claim, you must bring a completed dental insurance form or proof of insurance at each appointment.

Your **estimated** copayment for treatment, which is the amount not covered by your insurance, is due at the time treatment is provided. Your **estimated** copayment may be adjusted after the time of treatment depending upon the final reconciliation of insurance payments. Our practice accepts cash, personal checks, MasterCard, Visa, American Express, and Discover. Third party, extended payment financing is available upon request and approval.

Returned checks and balances older than 60 days will be subject to collection fees and finance charges at the rate of 1.5% per month (18% annually).

I acknowledge and agree that I will pay when applicable a Reservation Fee of \$50.00 up to a fee equal to 10% of scheduled treatment fees before reserving my next appointment. This fee will be forfeited if I do not give 48 business hours notice in advance for any changes or cancellation of said appointment. I also understand that once the dental appointment has been completed my insurance plan will be billed if applicable. Once insurance pays on the claim my account may show a credit balance which will be reimbursed to me or left on my account.

**Additionally, our practice will charge you for appointments that you do not keep and for appointments you do not cancel if 48 business hours advance notice is not given.**

Please do not hesitate to ask if you have any questions regarding this financial agreement. We are committed to providing you with the ultimate experience in dental care.

Print Name of Patient or Responsible Party: \_\_\_\_\_

Signature of Patient or Responsible Party: \_\_\_\_\_

Date: \_\_\_\_\_

## PATIENT INFORMATION (CONFIDENTIAL)

NAME \_\_\_\_\_ DATE \_\_\_\_\_  
FIRST MI LAST  
ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE/PROV. \_\_\_\_\_ ZIP/P.C. \_\_\_\_\_  
E-MAIL \_\_\_\_\_ CELL PHONE \_\_\_\_\_ HOME PHONE \_\_\_\_\_  
SS#/SIN \_\_\_\_\_ BIRTHDATE \_\_\_\_\_  
CHECK APPROPRIATE BOX:  MINOR  SINGLE  MARRIED  DIVORCED  WIDOWED  SEPARATED  
IF COLLEGE STUDENT, F.T. / P.T., NAME OF SCHOOL \_\_\_\_\_ CITY \_\_\_\_\_ STATE/PROV. \_\_\_\_\_  
PATIENT'S OR PARENT'S/GUARDIAN'S EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_  
BUSINESS ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE/PROV. \_\_\_\_\_ ZIP/P.C. \_\_\_\_\_  
SPOUSE OR PARENT'S/GUARDIAN'S NAME \_\_\_\_\_ EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_  
WHOM MAY WE THANK FOR REFERRING YOU? \_\_\_\_\_  
PERSON TO CONTACT IN CASE OF AN EMERGENCY \_\_\_\_\_ PHONE \_\_\_\_\_

## RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_  
ADDRESS \_\_\_\_\_ HOME PHONE \_\_\_\_\_  
DRIVER'S LICENSE # \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ SS#/SIN \_\_\_\_\_  
EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_  
IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE?  YES  NO

## INSURANCE INFORMATION

NAME OF INSURED \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_  
BIRTHDATE \_\_\_\_\_ SS#/SIN \_\_\_\_\_ DATE EMPLOYED \_\_\_\_\_  
NAME OF EMPLOYER \_\_\_\_\_ UNION OR LOCAL # \_\_\_\_\_ WORK PHONE \_\_\_\_\_  
EMPLOYER ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE/PROV. \_\_\_\_\_ ZIP/P.C. \_\_\_\_\_  
INSURANCE CO. \_\_\_\_\_ TEL. # \_\_\_\_\_ GRP # \_\_\_\_\_ POLICY / I.D. # \_\_\_\_\_  
INS. CO. ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE/PROV. \_\_\_\_\_ ZIP/P.C. \_\_\_\_\_  
HOW MUCH IS YOUR DEDUCTIBLE? \_\_\_\_\_ HOW MUCH HAVE YOU USED? \_\_\_\_\_ MAX ANNUAL BENEFIT? \_\_\_\_\_

## PHARMACY INFORMATION

Name \_\_\_\_\_  
Address \_\_\_\_\_  
\_\_\_\_\_  
Phone \_\_\_\_\_

X  
SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR \_\_\_\_\_

PATIENT NUMBER \_\_\_\_\_

REGISTRATION

# PATIENT'S MEDICAL HISTORY

PATIENT'S NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

ALTHOUGH DENTAL PERSONNEL PRIMARILY TREAT THE AREA IN AND AROUND YOUR MOUTH, YOUR MOUTH IS A PART OF YOUR ENTIRE BODY. HEALTH PROBLEMS THAT YOU MAY HAVE, OR MEDICATION THAT YOU MAY BE TAKING, COULD HAVE AN IMPORTANT INTERRELATIONSHIP WITH THE DENTISTRY THAT YOU WILL BE RECEIVING. THANK YOU FOR ANSWERING THE FOLLOWING QUESTIONS.

	YES	NO		YES	NO
1. ARE YOU IN GOOD HEALTH. . . . .	<input type="checkbox"/>	<input type="checkbox"/>	12. HAVE YOU EVER TAKEN FEN-PHEN/REDUX . . . .	<input type="checkbox"/>	<input type="checkbox"/>
2. HAVE THERE BEEN ANY CHANGES IN YOUR GENERAL HEALTH WITHIN THE PAST YEAR . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	13. HAVE YOU EVER TAKEN FOSAMAX, BONIVA, ACTONEL OR ANY CANCER MEDICATIONS CONTAINING BISPHTHOSPHONATES? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
3. DATE OF YOUR LAST PHYSICAL EXAM: _____			14. HAVE YOU TAKEN VIAGRA, REVATIO, CIALIS OR LAVITRA IN THE LAST 24 HOURS? . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
4. PHYSICIAN'S NAME _____ ADDRESS _____ PHONE NO. _____			15. DO YOU USE TOBACCO . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
5. ARE YOU NOW UNDER THE CARE OF A PHYSICIAN . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	16. DO YOU OR HAVE YOU USED CONTROLLED SUBSTANCES . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
6. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS PLEASE EXPLAIN. _____			17. ARE YOU WEARING CONTACT LENSES . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
7. ARE YOU TAKING ANY MEDICINE(S) INCLUDING NON-PRESCRIPTION MEDICINE . . . . . IF YES, WHAT MEDICINE(S) ARE YOU TAKING _____	<input type="checkbox"/>	<input type="checkbox"/>	18. DO YOU HAVE A PERSISTENT COUGH OR THROAT CLEARING NOT ASSOCIATED WITH A KNOWN ILLNESS (LASTING MORE THAN 3 WEEKS) . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
8. HAVE YOU HAD ANY ABNORMAL BLEEDING. . . . .	<input type="checkbox"/>	<input type="checkbox"/>	19. DO YOU HAVE ANY DISEASE, CONDITION OR PROBLEM NOT LISTED ABOVE THAT YOU THINK I SHOULD KNOW ABOUT . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
9. DO YOU BRUISE EASILY. . . . .	<input type="checkbox"/>	<input type="checkbox"/>	<b>WOMEN ONLY:</b>		
10. HAVE YOU EVER REQUIRED A BLOOD TRANSFUSION	<input type="checkbox"/>	<input type="checkbox"/>	ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
11. HAVE YOU HAD A RECENT WEIGHT LOSS . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	ARE YOU NURSING . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
			ARE YOU TAKING BIRTH CONTROL PILLS . . . . .	<input type="checkbox"/>	<input type="checkbox"/>

	YES	NO		YES	NO
<b>ARE YOU ALLERGIC TO OR HAVE YOU HAD REACTIONS TO:</b>			HIVES OR SKIN RASH. . . . .	<input type="checkbox"/>	<input type="checkbox"/>
LOCAL ANESTHETICS LIKE NOVOCAINE. . . . .	<input type="checkbox"/>	<input type="checkbox"/>	FAINING OR DIZZY SPELLS . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
PENICILLIN OR OTHER ANTIBIOTICS . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	DIABETES . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
SULFA DRUGS. . . . .	<input type="checkbox"/>	<input type="checkbox"/>	AIDS OR HIV INFECTION . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
BARBITURATES, SEDATIVES OR SLEEPING PILLS . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	THYROID PROBLEMS . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
ASPIRIN . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	ALLERGIES . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
IODINE. . . . .	<input type="checkbox"/>	<input type="checkbox"/>	ARTHRITIS OR RHEUMATISM . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
ANY METALS (E.G., NICKEL, MERCURY, ETC.) . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	JOINT REPLACEMENT OR IMPLANT . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
LATEX / RUBBER . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	STOMACH ULCER . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
OTHER (PLEASE LIST) _____			KIDNEY TROUBLE . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
<b>DO YOU HAVE OR HAVE YOU EVER HAD THE FOLLOWING:</b>			TUBERCULOSIS . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
RHEUMATIC HEART DISEASE OR RHEUMATIC FEVER	<input type="checkbox"/>	<input type="checkbox"/>	PERSISTENT COUGH . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
SCARLET FEVER. . . . .	<input type="checkbox"/>	<input type="checkbox"/>	COUGH THAT PRODUCES BLOOD . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
HEART DEFECT OR HEART MURMUR . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	CHEMOTHERAPY (CANCER, LEUKEMIA) . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
HEART TROUBLE, HEART ATTACK, OR ANGINA . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	SEXUALLY TRANSMITTED DISEASE . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
CHEST PAIN . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	EPILEPSY OR SEIZURES . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
SHORTNESS OF BREATH . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	ANEMIA . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
PACEMAKER . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	GLAUCOMA . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
HEART SURGERY . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	NERVOUSNESS . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
HIGH/LOW BLOOD PRESSURE . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	TONSILLITIS . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
CONGENITAL HEART PROBLEM . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	TUMORS . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
SWELLING OF FEET, ANKLES, HANDS. . . . .	<input type="checkbox"/>	<input type="checkbox"/>	MENTAL HEALTH CARE . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
HEPATITIS, JAUNDICE OR LIVER DISEASE . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	BACK PROBLEMS . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
STROKE . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	CHEMICAL DEPENDENCY . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
SINUS TROUBLE . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	MITRAL VALVE PROLAPSE . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
LUNG OR BREATHING PROBLEMS . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	CORTISONE TREATMENT . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
ASTHMA OR HAY FEVER . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	COLD SORES/FEVER BLISTERS . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
			HYPOGLYCEMIA . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
			EATING DISORDERS . . . . .	<input type="checkbox"/>	<input type="checkbox"/>

ITEM 27011

PATIENT'S NUMBER \_\_\_\_\_