South Texas Periodontics & Implants

Answers to the following questions are for our records only and will be considered confidential.

Name____________________________________ S.S.# _________________________ Date___________________

Address________________________ City______________ Zip____________ Home Phone__________________

Cell Phone ____________________________ E-mail Address____

Date of Birth____________ Age_______ Height_________ Weight_________ Marital status___________________

Occupation_________________________ Employer________________________ Work Phone___________________
Business Address__________________ City_____________ Zip_________ Driver's license #_________________
Spouse's Name_________________ Employer_____________________ Spouse's work phone___________________
Spouse's S.S.#______________________________Spouse's Date of Birth_________________
Dental Ins. Co._________________________________ Medical Ins. Co.____________________________________
Physician_______________________________ Address____________________ Telephone____________________
Pharmacy____ Phone #___________________________________
Dentist who referred you to a periodontist____
Reason for this visit____
Name and phone number of person to notify in a case of an emergency____

MEDICAL AND DENTAL HISTORY

Date of last complete medical examination________________ Date of last dental cleaning______________________
How many times a year do you have a Dental Cleaning? ____________
Are you in good health? YES NO
Are you presently under the care of a physician? YES NO
Explain: ____
Are you currently taking any drug or medication? YES NO
If so, what? ____
____
Have you ever taken Oral Bisphosphonates? For example, Fosamax, Actonel or Boniva YES NO
Do you take Aspirin daily? YES NO
Have you ever been hospitalized or had any serious illness within the past 5 years? YES NO
Explain:____

HAVE YOU EVER HAD:

Hepatitis or liver disease	YES	NO
Anemia	YES	NO
Epilepsy, convulsions or seizures	YES	NO
Kidney or bladder disease	YES	NO
Tuberculosis or emphysema	YES	NO
Heart trouble	YES	NO
Chest pain on exertion	YES	NO
Shortness of breath	YES	NO
Heart murmur	YES	NO
Rheumatic fever	YES	NO
High/Low blood pressure	YES	NO
Diabetes	YES	NO
Frequent urination	YES	NO
Often thirsty	YES	NO
Slow healing injuries	YES	NO
Family member with diabetes	YES	NO
Arthritis or rheumatism	YES	NO
Psychiatric treatment	YES	NO
Thyroid problems	YES	NO
Cancer	YES	NO
Medical treatment by radiation	YES	NO
AIDS/HIV infection	YES	NO
Glaucoma	YES	NO
Prostate trouble	YES	NO
Asthma/ Hayfever	YES	NO
Human Papilloma Virus	YES	NO
Sinus Problems	YES	NO
Ulcers	YES	NO
Any prosthetic devices (hip, heart valve, knee or other)	YES	NO
Surgery	YES	NO

Explain___________________

ALLERGIES:

Are you allergic to or have you had a reaction to:

Local anesthetics	YES	NO
Penicillin or other antibiotics	YES	NO
Valium, sedatives or sleeping pills	YES	NO
Aspirin or acetaminophen	YES	NO
Codeine or other narcotics	YES	NO
Other________________________	YES	NO

WOMEN:

Are you pregnant?	YES	NO
Are you taking birth control pills ?	YES	NO
Are you taking hormone medication?	YES	NO

MEN:

Are you taking Viagra, Cialis or Levitra?	YES	NO
If yes was it in the last 24-48 hours?	YES	NO

SOCIAL HISTORY:

Do you smoke? YES NO
Packs per day____Number of years________
Do you drink alcohol? YES NO
Drinks per week_____
Do you use recreational drugs? YES NO
Do you drink coffee or tea? YES NO

Any serious illness not listed: ____

DENTAL HISTORY:
Have you ever been treated for **periodontal disease** (pyorrhea)? YES NO
If yes, when__________________________
Have you ever had orthodontic treatment (braces)? YES NO
Do you have any soreness, pain or clicking in your jaw? YES NO
Have you had any kind of trauma to your mouth or jaw? YES NO
Do you clench or grind your teeth? YES NO
Have you had a bad previous dental experience? YES NO
Do you have a fear of dental treatment? YES NO
Have you had prolonged bleeding after
an injury or tooth extraction? YES NO
Do you bruise easily? YES NO
Have you noticed any loosening of your teeth? YES NO
Have you noticed any shifting or separating of teeth? YES NO
Does food tend to get caught between your teeth? YES NO
Are any of your teeth sensitive to hot, cold or sweets? YES NO
Do you suffer from pain and/or swelling of your gums? YES NO
Do your gums often bleed when you brush your teeth? YES NO
Do you have an unpleasant odor or taste in your mouth? YES NO
Do you have a family history of periodontal disease? YES NO
How often do you brush each day?__________________________________
Is your toothbrush: Soft ( ) Medium ( ) Hard ( )
Do you use dental floss? YES NO If *yes*, how often do you floss? _______________________
What else do you use to clean your teeth? (mouthrinse, toothpick etc.) _______________________________

CONSENT

I attest that to the best of my knowledge, the information provided above is accurate and complete. Any changes in health status or medications will be reported to the Doctor at the next dental visit following the change. I authorize the Doctor or his representative to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis and to develop proper treatment recommendations. I also authorize the Doctor or Hygienist to perform any and all forms of treatment, medication, and therapy indicated after all my questions are answered. Scheduling an appointment is interpreted as authorization for treatment. I also understand that the use of anesthetic agents embody certain risks. Responsibility for payment of dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made in advance. Furthermore, I acknowledge that where appropriate, credit bureau reports may be obtained.

SIGNATURE:_________________________________ DATE____________________

DOCTOR'S SIGNATURE_____________________________________

South Texas Periodontics & Implants

NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed and how you can get access to this information.

Please review it carefully
The privacy of your health information is important to us

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you, or to your family and friends you approve.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. You also have the right to request restrictions on disclosure of PHI (Personal Health Information), or alternative means of communication to ensure privacy.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law or by national security activities.

Abuse or Neglect: We may disclose your health information to appropriate authorities when we suspect abuse or neglect.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards or letters).

PATIENT RIGHTS

Access: You have the right to look at or receive copies of your health information with limited exceptions. If you request copies, we will charge you $25.00 to locate your information, and postage if you want the copies mailed to you.

Amendment: You have the right to request that we amend your health information.

South Texas Periodontics & Implants

QUESTIONS AND COMPLAINTS
If you want more information about our privacy practices or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint about us with the U.S. Department of Health and Human Services.

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT FOR NECESSARY USE OF PERSONAL HEALTH INFORMATION.

____

Print Patient's Name   Date

I, ____, have received
(Signature of Patient)

a copy of this office's NOTICE OF PRIVACY PRACTICES as required by federal law.

I, ____, consent to the use and disclosure of
(Signature of Patient)

my personal health information by your office during Treatment, Billing/Payment and Dental Office

operations as outlined in the Notice of Privacy Practices.