BRUCE EDELSTEIN DDS, PC

Periodontics
Implants
Regenerative Techniques

W E L C O M E

ABOUT YOU

TODAY'S DATE: _____

Name: _____

I prefer to be called: _____

Male Female

Single Married Domestic Partner Widowed

Home Address: _____

_____

Primary Phone: ( )_____

Home ( ) Cell ( ) Work ( )

Email Address:_____

Social Security Number: _____

Birthdate: _____

Employer:_____

Occupation: _____

Whom may we thank for referring you: _____

Previous/Present Dentist: _____

Other family members seen by us: _____

SPOUSE OR SIGNIFICANT OTHER INFORMATION (IF APPLICABLE)

Name:_____

Employer:_____

Cell Phone: ( )_____

SSN: _____ DOB: _____

ACCOUNT INFORMATION

Person Responsible for Account: _____

Relation: _____

SSN: _____ DOB:_____

Cell Phone: ( ) _____

Billing Address: _____

_____

Employer:_____

IF YOU HAVE INSURANCE YOU MAY WISH TO UTILIZE, PLEASE PRESENT YOUR CARDS.

MEDICAL HISTORY

Your current overall health is: ☐ Good ☐ Fair ☐ Poor

Do you have a personal physician? ☐ Yes ☐ No

Physician's name: _____

Phone number: ( )_____

Please list all medications: _____

_____

_____

_____

HAVE YOU EVER HAD ANY OF THE FOLLOWING? (Circle)

Y N Asthma	Y N Heart Murmur/Mitral Valve
Y N Arthritis/Rheumatoid	Y N Heart Surgery/Pacemaker
Y N Anemia	Y N Hemophilia/Abnormal Bleeding
Y N Artificial Bones/Joints	Y N Hepatitis
Y N Artificial Valves	Y N High/Low Blood Pressure
Y N Autoimmune Disease	Y N HIV+/AIDS
Y N Blood Transfusion	Y N Kidney/Liver Disease
Y N Blood Thinning Medications	Y N Low Bone Density/OsteoPorosis
Y N Cancer/Chemotherapy	Y N Osteopenia Medications
Y N Congenital Heart Defect	Y N Premedicate for Dental Visits
Y N Diabetes	Y N Psychiatric Problems
Y N Difficulty Breathing	Y N Radiation
Y N Drug/Alcohol Abuse	Y N Scarlet/Rheumatic Fever
Y N Emphysema	Y N Severe/Frequent Headaches
Y N Epilepsy/Seizures	Y N Shingles
Y N Fever Blisters/Herpes	Y N Sinus Problems
Y N Glaucoma	Y N Stroke
Y N Heart Attack	Y N Tuberculosis

Please list any other medical condition(s) that you have had:

_____

_____

_____

_____

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

☐ Aspirin	☐ Latex
☐ Codeine	☐ Penicillin
☐ Dental Anesthetics	☐ Tetracycline
☐ Erythromycin	☐ Other_____

FOR WOMEN:

Are you pregnant? ☐ Yes ☐ No Week # _____

Are you nursing? ☐ Yes ☐ No

PERIODONTAL HISTORY

What are we evaluating today? _____

_____

Have you had previous periodontal treatment? ☐ Yes ☐ No

If so, what and when? _____

_____

_____

Date of last teeth cleaning: _____

Do you have a family history of gum disease? ☐ Yes ☐ No

Do your gums ever bleed? ☐ Yes ☐ No

Do you like to smile? ☐ Yes ☐ No

Do you smoke/use tobacco? ☐ Yes ☐ No

Do you now or have you ever experienced pain/discomfort In you jaw joint? ☐ Yes ☐ No

Have you ever had any serious/difficult problems associated with any previous dental work? ☐ Yes ☐ No

Explain: _____

Is this a 2nd opinion today? ☐ Yes ☐ No

Is there anything else you would like us to know regarding your periodontal health? _____

_____

_____

IN THE EVENT OF AN EMERGENCY, WHO MAY WE CONTACT?

Name: _____

Relation: _____

Best Contact #: ( )_____

MEDICAL HISTORY SIGNATURE

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____

Signature (if patient is under 18, parent or guardian) Date

PAYMENT IS DUE IN FULL AT THE TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED.

– OFFICE USE ONLY–

I have verbally reviewed the medical/periodontal history about with the patient named herein.

Signature: _____ **Date:** _____

Comments: _____

Bruce A. Edelstein, DDS, PC

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient #: _____ Social Security #: _____

See Chart

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. Bruce A. Edelstein, DDS, PC

Telephone: 404-352-1911 Fax: 404-352-3661

E-mail: drbruce@baegumdoc.com

Address: 2045 Peachtree Road, NE Suite 416, Atlanta, GA 30309

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's Name: _____

Relationship to Patient: _____

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

Include completed Consent in the patient's chart.