Bay Area Periodontics & Dental Implants

Practice Limited to Periodontics and Dental Implants
17201 Feathercraft • Webster, TX • 77598
(281) 486-6905

Dr. Hailey and his staff want to personally welcome you to our periodontal and implant practice. Our goal is to help you achieve and maintain complete oral health. If you have any questions regarding this medical history form, please feel free to ask us for assistance. Complete records allow us to better care for your overall oral health. **PLEASE PRINT AND COMPLETE THIS FORM - BRING IT WITH YOU TO YOUR APPOINTMENT**

A About You

Today's Date: ______________

Email Address: ______________

Name ______________

I prefer to be called: ______________ ☐ Male ☐ Female

Birthdate:___/___/___ Age:____ SS#:_____-_____-_______

Home Address: ______________

City: ______________ State: __________ ZipCode: ________

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Hm #: (_____) _____-_________ Cell # (_____) _____-______

Wk #: (_____) _____-_______ Ext:____ DL #: ______________

Employer: ______________

Employer's Address: ______________

How long there? _________ Occupation: ______________

Where & When are the best times to reach you? ______________

Whom may we Thank for referring you? ______________

Other family members seen by us: ______________

General Dentist: ______________

Last Visit Date: ______________

B Spouse Information

Name: ______________

Employer: ______________

Wk #: (_____) _____-_______ Ext:____ SS#: _____-____-_____

Birthdate:___/___/_____ DL #: ______________

C Responsible Party

Person Responsible for Account: ______________

Wk #:(_____) _____-_______ Ext:____ Hm #: (____) ____-_____

Billing Address: ______________

Relation: ______________ SS #:_______-______-__________

Employer: ______________ DL #: ______________

D Dental Insurance

Primary Dental Insurance

Insurance Co. Name: ______________

Insurance Co. Address: ______________

Insurance Co. Phone #: (_____) ______-__________

Group # (Plan, Local or Policy #): ______________

Insured's Name: ______________ Relation: ______________

Insured's Birthdate:___/___/___ Insured's ID #: ______________

Insured's Employer: ______________

Secondary Dental Insurance

Insurance Co. Name:

Insurance Co. Address: ______________

Insurance Co. Phone #: (_____) ______-__________

Group # (Plan, Local or Policy #): ______________

Insured's Name: ______________ Relation: ______________

Insured's Birthdate:___/___/___ Insured's ID #: ______________

Insured's Employer: ______________

E Dental History

Why have you come to the dentist today?

____

____

Has your doctor told you that you require antibiotics before dental treatment? ☐ Yes ☐ No

Are you currently in pain? ☐ Yes ☐ No

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

Do you or have you ever experienced pain/disomfort in your jaw joint (TMJ/TMD)? ☐ Yes ☐ No

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

Do you like your smile? ☐ Yes ☐ No

Do your gums ever bleed? ☐ Yes ☐ No

How many times a week do you floss?_____

How many times a day do you brush?_____

Type of bristles? ☐ Hard ☐ Medium ☐ Soft

Medical History

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name:______________________________

Phone #: (____)_____-________ Last Visit Date:__________

Are you currently under the care of a physician? ☐ Yes ☐ No

Please Explain: ______________________________

In the event of an emergency, is there someone who lives near you that we should contact?

His/Her Name:________________ Relation:____________

Wk #: (_____) _____-________ Hm #: (_____) _____-________

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

Do you smoke or use tobacco in any form? ☐ Yes ☐ No

Are you taking any prescription/over-the-counter or herbal supplement drugs? ☐ Yes ☐ No

Please list each one:______________________________

____

Have you ever taken Fosamax or any other bisphosphonate? ☐ Yes ☐ No

Have you ever taken Phen-fen? ☐ Yes ☐ No

For Women: Are you using a prescribed method of birth control? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Week #________

Are you nursing? ☐ Yes ☐ No

Have you ever had any of the following diseases or medical problems?

- ☐ Abnormal Bleeding
- ☐ Alcohol/Drug Abuse
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Bones / Joints / Valves
- ☐ Asthma
- ☐ Blood Transfusion
- ☐ Cancer/Chemotherapy
- ☐ Colitis
- ☐ Congenital Heart Defect
- ☐ Diabetes
- ☐ Difficulty Breathing
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting Spells
- ☐ Frequent Headaches
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Heart Surgery
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ Herpes/Fever Blisters
- ☐ High Blood Pressure
- ☐ HIV+ / AIDS
- ☐ Hospitalized for any Reason
- ☐ Kidney Problems
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lupus
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Psychiatric Problems
- ☐ Radiation Treatment
- ☐ Rheumatic/Scarlet Fever
- ☐ Seizures
- ☐ Shingles
- ☐ Sickle Cell Disease
- ☐ Sinus Problems
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tubercolosis (TB)
- ☐ Ulcers
- ☐ Venereal Disease

Medical History

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

____

____

Are you allergic to any of the following?

☐ Aspirin	☐ Erythromycin	☐ Penicillin
☐ Codeine	☐ Jewelry/Metals	☐ Tetracycline
☐ Dental Anesthetics	☐ Latex	☐ Other:

____

____

Please list any other drugs/materials that you are allergic to:

____

____

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 the strictest of 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 **Date**

Payment is due in full at time of treatment unless prior arrangements have been approved.

Our office is HIPAA Compliant and committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

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I verbally reviewed the medical/dental information above with the patient named herein. Initials: ________ Date: ____/____/______

Doctor's comments: ______________________________

____

MEDICAL HISTORY UPDATE

1. Date:____/____/______ Comments:______________________ Signature:______________________
2. Date:____/____/______ Comments:______________________ Signature:______________________
3. Date:____/____/______ Comments:______________________ Signature:______________________

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Dear Patient:

Welcome to our family of fine patients. We would like to let you know how pleased we are that you have chosen our office for your periodontal needs. It is our privilege to serve you and to provide you with the best possible care.

We would like to take this opportunity to make you aware of our office policies:

Payment for all services will be due in full at the time of service. You the patient are responsible for all charges incurred at this office. We accept cash, check, money order, Visa, MasterCard or CareCredit. There will be a $30.00 charge for any returned checks.

If you have a dental insurance, our office will submit insurance claims to your carrier for payment as courtesy to you. This relieves you from having to pay for the entire procedure at this time of service. Your portion is calculated by information given to our office when we call to verify your insurance coverage. **Your portion is only an estimate and not guarantee of payment. If your insurance carrier does not pay within 60-days from the time of service, you are responsible for payment in full. We will send monthly statements to let you know the status of your account. "You" the patient are encouraged to keep up with the status of your claim.**

We require at least a 24-hour notice for changes in appointments. This allows other patients to take advantage of available changes in the schedule. **If an appointment is broken without a 24-hour notice, a $25.00 charge will be assessed. There is a $75.00 charge for all surgery changes without a 24-hour notice.**

Again, it is our privilege to care for your dental implant and periodontal needs. Should you ever have any questions or concerns, please do not hesitate to call.

Sincerely,

Gary L. Hailey D.D.D., M.S., P.A.

Jared Abramian D.D.S., M.S.D.

Patient Signature: ______________________________________ Date: ___/___/_____

NOTICE OF PRIVACY

As a provider of medical services we are required under the Health Insurance Portability and Accountability act, to inform you of your rights to protect your personal health information. As a covered entity, we must inform all of their rights regardless of insurance coverage.

OUR DUTY TO YOU

As your dental provider we will do everything within our control to maintain your records and information in a secure and private manner. We do reserve the right to change our policies, but you will be informed of any changes in advance. We will only release information, about you and your treatment under specific circumstances. These include, but are not limited to the following:

Treatment: We may use your information during the course of treatment. This includes releasing information to other dentists, physicians, other health care providers, and our staff. Out staff includes full and part time employees as well as temporary personnel.

Payment: We may disclose personal information about you and your treatment to third party carriers and payment processing entities. This includes carriers, claims clearinghouses, collection agencies and third party administrators such as employee reimbursement accounts.

Operations: We may use your personal information in the course of operations of our office. This may include quality assurance/quality improvement reviews, credentialing training, and certification and accreditation activities.

Miscellaneous Uses: At certain times we may be required to use your information for other purposes than as described above. Examples of these uses include: appointment reminders (cards, voice messages and letters), abuse/neglect, national security, family and friends (only to the extent for use in healthcare operation or payment) and in some cases to law enforcement and court ordered releases.

YOUR RIGHTS

Restrictions: You have the right to restrict to request restrictions or disclosure usage. We are not required to accept these restrictions but will make a note of the request and honor the request if applicable.

Access: You have the right to access your personal health information. A request for access must be made in writing. You may speak to our privacy officer to schedule an appointment to view your information. You may also request a copy of your personal health information. We will charge you a fee for the copies as set by the Texas State Board of Dental Examiners.

Amendment: You have the right to request a list of the times and entities to whom we have disclosed your personal health information. Your request must be in writing and explain what should be amended and the rationale for such request. We have the right to deny this request if we feel that it would render your information inaccurate. We will inform you of the decision to amend your information.

Disclosures: You have the right to request a list of the times and entities to whom we have disclosed your personal health information. These disclosures are only for instances other than treatment, payment or operations. This disclosure will be given free on an annual basis if requested. We reserve the right to charge for this if requested more than once in a 12 month period.

Complaints: Please contact our privacy officer for any questions or complaints. If you feel that we have violated your privacy, you can submit a written complaint to the U.S. Department of Health and Human Services. We can provide you with the address upon request.