HENRY A. SACHS, D.D.S.

PERIODONTICS AND IMPLANT DENTISTRY

DIPLOMATE, AMERICAN BOARD OF PERIODONTOLOGY • MEMBER AMERICAN ACADEMY OF IMPLANT DENTISTRY

PATIENT REGISTRATION

Date:_____Phone # _____E-mail_____

Name:_____ Birthdate _____ Age _____

Address:_____

City: _____ State: _____Zip:_____ SS#_____

Occupation: _____ Spouse's Name:_____

Employer: _____ Business Phone#_____

Emergency contact name and phone number _____

If Referred, by whom? ____ My Dentist Other_____

Your Dentist's Name: _____ Phone #_____

Address: _____State: _____ Zip:_____

Your Physician's Name: _____ Phone #_____

Address: _____State: _____ Zip:_____

What is your chief concern? : _____

Your Pharmacy? Name:_____ Tel:_____ Address:_____

Do You Require Nitrous Oxide for Treament?:_____

DENTAL INSURANCE INFORMATION

Subscriber's Name: _____ Birthdate: _____

Employer: _____ Soc. Sec.#_____

Insurance Co. _____ Group No._____

Deductible:_____ Maximum Annual Benefit: _____

Relationship to subscriber ____Self ____Spouse ____Child ____Other_____

SECONDARY DENTAL INSURANCE PLAN (if applicable)

Subscriber's Name:_____ Birthdate: _____

Employer: _____ Soc. Sec.#_____

Insurance Co._____ Group #_____

1181 Old Country Road - Suite 2, Plainview, NY 11803 • Tel. (516) 932-3050 • Fax: (516) 932-0911

Patient Medical History

PHYSICIAN_____ OFFICE PHONE _____DATE OF EXAM _____

	YES	NO
1. Are you under medical treatment now?	❑	❑
2. Have you been hospitalized for any surgical operation or serious illness in the past 5 years?	❑	❑
3. Are you taking any medication(s) including non-prescription medicine?	❑	❑
a. If yes, what medication(s) are you taking?	❑	❑
b. Do you need to take antibiotics before treatment?	❑	❑
4. Do you use tobacco?	❑	❑
5. Do you use alcohol, cocaine or other drugs?	❑	❑
6. Are you wearing contact lenses?	❑	❑
	❑	❑

7. Are you allergic to or have you had any reactions to the following?

	YES	NO		YES	NO		YES	NO
Local anesthetics (eg . novocaine)	❑	❑	Barbiturates	❑	❑	Aspirin	❑	❑
Penicillin or other antibiotics	❑	❑	Sedatives	❑	❑	Other	❑	❑
Sulfa Drugs	❑	❑	Iodine	❑	❑		❑	❑

8. WOMEN ONLY

	YES	NO
a) Are you pregnant or think you may be pregnant?	❑	❑
b) Are you nursing?	❑	❑
c) Are you taking birth control pills?	❑	❑

9. Do you have or have you ever had any of the following:

YES	NO		YES	NO		YES	NO	
❑	❑	High Blood Pressure	❑	❑	Heart Disease	❑	❑	Chest Pains
❑	❑	Heart Attack	❑	❑	Cardiac Pacemaker	❑	❑	Easily Winded
❑	❑	Rheumatic Fever	❑	❑	Heart Murmur	❑	❑	Stroke
❑	❑	Swollen Ankles	❑	❑	Angina	❑	❑	Hay Fever/Allergies
❑	❑	Fainting/Seizures	❑	❑	Frequently Tired	❑	❑	Tuberculosis
❑	❑	Asthma	❑	❑	Anemia	❑	❑	Radiation Therapy
❑	❑	Low Blood Pressure	❑	❑	Emphysema	❑	❑	Glaucoma
❑	❑	Epilepsy/Convulsions	❑	❑	Cancer	❑	❑	Recent Weight Loss
❑	❑	Leukemia	❑	❑	Arthritis	❑	❑	Liver Disease
❑	❑	Diabetes	❑	❑	Joint Replacement or Implant	❑	❑	Heart Trouble
❑	❑	Kidney Diseases	❑	❑	Hepatitis/Jaundice	❑	❑	Respiratory Problems
❑	❑	AIDS or HIV Infection	❑	❑	Sexually Transmitted Disease	❑	❑	Other
❑	❑	Thyroid Problem	❑	❑	Stomach Problems/Ulcers			

10. Are you feverish?	❑ YES	❑ NO
11. In the last 21 days have you been to Sierra Leone, Liberia or Guinea?	❑ YES	❑ NO

PATIENT DENTAL HISTORY

	YES	NO		YES	NO
1. Do your gums bleed while brushing or flossing?	❑	❑	8. Do you have frequent headaches?	❑	❑
2. Are you sensitive to hot or cold liquids/foods?	❑	❑	9. Do you clench or grind your teeth?	❑	❑
3. Are your teeth sensitive to sweet or sour liquids/foods?	❑	❑	10. Do you bite your lips or cheeks frequently?	❑	❑
4. Do you feel pain in any of your teeth?	❑	❑	11. Have you ever had any difficult extractions in the past?	❑	❑
5. Do you have sores or lumps in or near your mouth?	❑	❑	12. Have you had any orthodontic work?	❑	❑
6. Have you had any head, neck or jaw injuries?	❑	❑	13. Have you ever had prolonged bleeding following extractions?	❑	❑
7. Have you ever experienced any of the following problems in your jaw?	❑	❑	14. Have you ever had instruction on the correct method of brushing your teeth?	❑	❑
a) Clicking?	❑	❑	15. Have you ever had instruction for the care of your gums?	❑	❑
b) Pain (joint, ear, side or face?)	❑	❑		❑	❑
c) Difficulty in opening or closing?	❑	❑		❑	❑
d) Difficulty chewing?	❑	❑		❑	❑

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Laser Periodontics and Implant Dentistry
Diplomate, American Board of Periodontology • Member, American Academy of Implant Dentistry
www.doc4gums.com

PATIENT HIPAA AGREEMENT

With my permission, Dr. Henry Sachs may use and disclose protected health information (PHI) about me to conduct treatment, payment and healthcare operations. Please refer to Dr. Henry Sachs' Notice of Privacy Practices for more complete descriptions of such uses and disclosures'

I have the right to review the Notice of Privacy Practices prior to signing this consent. Dr. Henry Sachs reserves the right to revise his Notice of Privacy Practices at any time. You may obtain a revised notice by forwarding a written request to the Privacy Officer.

THIS WAIVER AUTHORIZES DR. HENRY SACHS TO SEND/ GIVE MY PHI INFORMATION AS NOTED. INDICATE YES OR NO TO THE FOLLOWING:

Yes/ No

1. ---------- leave a voice mail recording including my PHI on my home phone.
2. ---------- leave a voice mail recording including my PHI on my cell phone.
3. ---------- leave a voice mail recording including my PHI on my business phone.
4. ----------leave a voice mail regarding only appointment confirmations on my home, cell phone of business phone number.
5. ---------- use of electronic communications (fax, email, electronic messaging to confirm patient's appointment.
6. ---------- speak to a family member of my choosing(Personal Representative, designated below) regarding my PHI.
7. ----------contact designated locations in reference to any items that assist in my healthcare, such as insurance items, including lab results, etc.

Name & relationship of designated personal representative:
(print)_____

By signing this, I am allowing Dr. Henry Sachs to use and disclose my PHI.
I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior request.

Print/ sign: Name of patient/legal guardian_____
Date_____

I certify that I have read and understand the above information and to the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

SIGNATURE **X**_____ _____

Patient, Parent or Guardian **Date**