Garazi
Periodontics & Dental Implants

REGISTRATION HISTORY

DATE: ________________

Patient's Name: ______________________________ Marital Status: ______________

Patient's Social Security Number: ______________________ Home Phone: (____)__________

Street Address: ______________________________ Cell Phone: (____)__________

City & State: __________________ Zip Code: ______ Bus. Phone: (____)__________

Name of Spouse: ______________________________ Email: ______________

If patient is a minor, Parent's names: ______________________________

In case of emergency, who should be notified? ______________ Cell Phone: (____)

Your Employer: ______________________________ Your Occupation: ______________

Dental Insurance Company: ______________________ Policy holder name: ______________

Member ID #______________ Group #______________ Date of Birth: ______________

Whom may we thank for referring you to our office? ______________________________

HEALTH HISTORY

1. Date of Birth: __________ Age:______ Sex:______ Height:________ Weight:________
2. Has there been any change in your health within the past year? Circle: Yes or No
If yes, please explain:
3. Date of last physical examination:________ Name of Pharmacy and Phone # ______________
   a. Name of your physician:__________________ Physician phone #:______________
4. Are you being treated for any specific conditions? Circle: Yes or No
If yes, please explain: ______________________________
5. Have you been hospitalized or had a severe illness within the past five years? Circle: Yes or No
If yes, please explain: ______________________________
6. Do you premedicate with antibiotics for dental visits? Yes or No If yes, why? ______________
7. Do you have, or have you ever had any of the following diseases or conditions: Please circle Yes or No

Yes	No	Covid Date of ______________
Yes	No	Covid Vaccine Date of ______________
Yes	No	Abnormal heart condition
Yes	No	Prosthetic Heart Valves
Yes	No	Abnormal blood pressure - If yes, circle: High or Low
Yes	No	Diabetes – If yes, circle: Type I or Type II Most Recent HbA1c: ______________
Yes	No	Osteoporosis or Osteopenia
Yes	No	HIV+ or any other infectious disease? ______________
Yes	No	Joint Replacement (knee, hip, etc.) Please list: ______________
Yes	No	Hepatitis, jaundice or liver disease
Yes	No	Blood transfusion. If so, when and for what? ______________
Yes	No	Kidney disorders
Yes	No	Anemia
Yes	No	Stomach ulcers
Yes	No	Cancer – If yes, currently in treatment? ______________

Yes No Sinus condition
Yes No Fainting spells
Yes No Seizures (epilepsy)

Any other condition not listed above? Please list ____________________

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8. Have you had abnormal bleeding associated with previous extractions, surgery, cuts, or trauma?
   Yes or No If yes, please explain: ____________________

9. Are you presently taking any of the following medications: Please circle Yes or No and list medication
   - Yes No Antibiotics, if yes, which and for what: ____________________
   - Yes No Blood thinners (anticoagulants) including Aspirin: ____________________
   - Yes No Medicine for high blood pressure: ____________________
   - Yes No Water pills (diuretics): ____________________
   - Yes No Cortisone (steroids): ____________________
   - Yes No Tranquilizers: ____________________
   - Yes No Antihistamines: ____________________
   - Yes No Advil, Tylenol or other Pain Medications: ____________________
   - Yes No Insulin or other medication for diabetes: ____________________
   - Yes No Medication for heart trouble: Inderal digitalis, or other: ____________________
   - Yes No Nitroglycerin: if yes,how often? ____________________
   - Yes No Medications for Osteoporosis or bone density: ____________________
   - Yes No Other (please be specific) ____________________

10. Are you allergic to or have you reacted adversely to:
    - Yes No Local anesthetics (Novacaine) or other, please list: ____________________
    - Yes No Penicillin or other antibiotics: ____________________
    - Yes No Tranquilizers, sedatives or sleeping pills: ____________________
    - Yes No Codeine or other pain medication: ____________________
    - Yes No Aspirin
    - Yes No Other (please be specific): ____________________

11. If a woman, are you pregnant? Circle: Yes or No If yes, when is your due date? ____________________
12. Do you smoke: Yes or No If yes, what and how much? ____________________
13. Do you drink alcohol? Yes or No Occasionally? Weekends? More than 2 drinks a day ____________________
14. Does food get stuck between your teeth? Yes or No Which location? ____________________
15. Do your gums bleed? Yes or No When and which location? ____________________
16. Do you grind your teeth? Yes or No If yes, Daytime? Nighttime? Other?: ____________________
17. Are you missing any teeth you would like to replace? Yes or No ____________________

RESPONSIBILITY AND CONSENT STATEMENT

This is to certify that I, the undersigned, have given an accurate medical history to the best of my knowledge. I consent to the examination, X-rays or procedures agreed to be necessary or advisable, including the use of sedation or general anesthetics as indicated: I consent to the taking of photographs to be used for teaching purposes. I will assume responsibility for fees associated with those procedures including attorneys' fees associated with collection of unpaid balances. All appointments cancelled with less than 48 hours notice will be subject to a charge.

PLEASE SIGN

Patient's Signature: ____________________ Date: ____________ Dr. Signature: ____________________

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

"You May Refuse To Sign This Acknowledgment"

I. ____

have received a copy of this office's Notice of Privacy Practices.

Print Name ______________________________________

Signature ______________________________________

Date ______________________________________

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient Name ______________________________________

Address ______________________________________

Telephone Number ______________________________

I authorize the office of Garazi Periodontics and Dental Implants to communicate with other doctors and release health information identifying me (including x rays if applicable , information about HIV)

______________________ ______________________
Signature Date

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices but acknowledgment could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining the acknowledgment
- ☐ Other (Please Specify) ______________________________________