Denver Periodontal
Implant & Oral Wellness

8200 East Belleview Avenue
Suite 450 East Tower
Greenwood Village, CO 80111
Phone (303) 779-6924
Fax (303) 741-2777
contact@denverperioimplant.com

DR. SAROJ KUMAR SAHA, D.D.S., M.S.D.

Confidential Patient Information (Please Print)

Name_____ Birthdate_____ Social Security #_____

Address_____ City_____ State_____ Zip Code_____

Home Phone_____ Work Phone_____ Cell Phone_____

Single_____ Married_____ Widowed_____ Divorced_____ Separated_____ Minor_____

Patient or Parent's Employer_____ E-mail address_____

Business Address_____ City_____ State_____ Zip Code_____

Spouse or Parent's Name_____ Employer_____ Work Phone_____

If Patient is a student, Name of School_____ City_____ State_____

Whom may we thank for referring you?_____

Contact in case of emergency_____ Phone_____

Insurance Information

Name of insured_____ Relationship to Patient_____

Birthdate of insured_____ Social Security #_____ Date Employed_____

Name of Employer_____ Work Phone_____

Address_____ City_____ State_____ Zip Code_____

Insurance Company_____ Group #_____ Union or Local #_____

Insurance Address_____ City_____ State_____ Zip Code_____

Phone number_____ Deductible_____ Max annual benefit_____

Do you have additional insurance? If so, please complete the following information.

Name of insured_____ Relationship to Patient_____

Birthdate of insured_____ Social Security #_____ Date Employed_____

Name of Employer_____ Work Phone_____

Address_____ City_____ State_____ Zip Code_____

Insurance Company_____ Group #_____ Union or Local #_____

Insurance Address_____ City_____ State_____ Zip Code_____

Phone number_____ Deductible_____ Max annual benefit_____

Signature **X** _____ Date_____

Signature of Patient or Parent if Minor

POS Reorder # 1915439

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HEALTH QUESTIONNAIRE

Name _____ Birth date _____

Correct answers to the following questions will allow your dentist to treat you on a more individual basis, providing the care appropriate for your particular needs. Circle yes or no, whichever applies, in response to the following questions. Your answers are for our records only and will be considered confidential.

DENTAL

1. Are you having any discomfort at this time? Yes No
2. Have you ever had any serious trouble associated with previous dental treatment? Yes No
   If so, explain? _____
3. Does dental treatment make you nervous? No _____ Slightly _____ Moderately _____ Extremely _____
4. Date of last dental visit _____
5. Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth? Yes No
   If so, when? _____
6. How often do you brush? _____
   Brush is: Soft ❑ Medium ❑ Hard ❑
7. Do you have or have you ever had any of the following?

MOUTH

Bleeding, sore gums	Yes	No
Unpleasant taste/bad breath	Yes	No
Burning tongue/lips	Yes	No
Frequent blisters, lip/mouth	Yes	No
Swelling/lumps in mouth	Yes	No
Ortho treatments (braces)	Yes	No
Biting cheeks/lips	Yes	No
Clicking/popping jaw	Yes	No
Difficulty opening or closing jaw	Yes	No

8. Do you use the following?

Brush	Yes	No
Dental floss	Yes	No
Fluoride rinse	Yes	No

Other _____

TEETH

Loose Teeth	Yes	No
Sensitive to hot	Yes	No
Sensitive to cold	Yes	No
Sensitive to sweets	Yes	No
Sensitive to biting	Yes	No
Food impaction	Yes	No
Clenching/grinding	Yes	No
If so, when? _____		
Shifting in bite	Yes	No
Change in bite	Yes	No

MEDICAL

1. Has there been any change in your general health within the past year? Yes No
2. My last physical examination was on _____
3. Are you now under the care of a physician? Yes No
   If so, what is the condition being treated? _____
4. The name and address of my physician is _____
   _____
5. Have you had any serious illness within the past five (5) years? Yes No
   If so, what was the illness? _____
6. Have you been hospitalized or had an operation within the past five (5) years? Yes No
   If so, what was the problem? _____
7. Do you have or have you had any of the following diseases or problems?
   a. Rheumatic fever or rheumatic heart disease Yes No
   b. Congenital heart disease Yes No
   c. Cardiovascular disease (heart trouble, heart attack, heart murmur, coronary insufficiency, coronary occlusion, high/low blood pressure, arteriosclerosis, stroke, etc.) Yes No
      1) Do you have pain in chest upon exertion? Yes No
      2) Are you ever short of breath after mild exercise? Yes No
      3) Do your ankles swell? Yes No
      4) Do you get short of breath when you lie down, or do you require extra pillows when you sleep? Yes No
   d. Artificial or replacement valves Yes No
   e. Pacemaker Yes No
   f. Allergy Yes No
   g. Sinus trouble Yes No
   h. Asthma or hay fever Yes No
   i. Hives or a skin rash Yes No
   j. Fainting spells or seizures Yes No

k. Diabetes ..... Yes No
1) Do you have to urinate (pass water) more than six times a day? ..... Yes No
2) Are you thirsty much of the time? ..... Yes No
3) Does your mouth frequently become dry? ..... Yes No
l. Hepatitis, jaundice or liver disease ..... Yes No
m. Arthritis or inflammatory rheumatism ..... Yes No
n. Artificial or replacement joints, prosthetic ..... Yes No
o. Digestive system—Ulcers or stomach disorders (colitis) ..... Yes No
p. Kidney trouble ..... Yes No
q. Tuberculosis ..... Yes No
r. Persistent cough or cough up blood ..... Yes No
s. Immune System disorders (including AIDS, HIV, ARC) ..... Yes No
t. Venereal disease ..... Yes No
u. Other _____

8. Have you had abnormal bleeding associated with previous extractions, surgery or trauma? ..... Yes No
a. Do you bruise easily? ..... Yes No
b. Have you ever required a blood transfusion? ..... Yes No
If so, explain the circumstances & when _____
9. Have you ever tested positive for the AIDS virus? ..... Yes No
10. Do you have any blood disorder such as anemia? ..... Yes No
11. Have you had surgery or x-ray treatment for a tumor, growth, or other condition? ..... Yes No
12. Are you taking any of the following:
a. Antibiotics or sulfa drugs ..... Yes No
b. Anticoagulants (blood thinners) ..... Yes No
c. Medicine for high blood pressure ..... Yes No
d. Cortisone (steroids) ..... Yes No
e. Tranquilizers ..... Yes No
f. Antihistamines ..... Yes No
g. Aspirin ..... Yes No
h. Insulin, tolbutamide (Orinase) or similar drug for diabetes ..... Yes No
i. Digitalis or drugs for heart trouble ..... Yes No
j. Nitroglycerin ..... Yes No
k. Other medications ..... Yes No
l. If "Yes" to any of the above, state drug name, dosage and frequency _____
13. Are you allergic or have you reacted adversely to:
a. Local anesthetics ..... Yes No
b. Penicillin or other antibiotics ..... Yes No
c. Sulfa drugs ..... Yes No
d. Barbiturates, sedatives, or sleeping pills ..... Yes No
e. Aspirin ..... Yes No
f. Iodine ..... Yes No
g. Codeine or other narcotics ..... Yes No
h. Other _____
14. Do you use any tobacco products? ..... Yes No
If so, how much per day and what _____
15. Do you use any alcohol products? ..... Yes No
If so, how much per day/week/month and what _____
16. Do you use any caffeinated products (coffee, tea, chocolate, etc.)? ..... Yes No
If so, how much per day and what _____
17. Do you have any disease, condition, or problem not listed above that you think I should know about? ..... Yes No
If so, explain _____
_____
18. Are you employed in any situation which exposes you regularly to x-rays or other ionizing radiation? ..... Yes No
19. Are you wearing contact lenses? ..... Yes No
20. Are you experiencing stress or pressure in your work or at home? ..... Yes No

WOMEN

20. Are you pregnant? ..... Yes No
21. Do you have PMS or problems associated with your menstrual period? ..... Yes No
22. Are you taking birth control or hormone therapy? ..... Yes No

Remarks:

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health or change in my medication, I will inform the dentist at the next appointment.

Signature of Patient Date Signature of Dentist Date

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OFFICE POLICY

IN ORDER TO PRESERVE OUR HIGH LEVEL OF PATIENT CARE AND MAINTAIN LOWER FEES TO OUR PATIENTS, WE ASK THAT 24 HOURS NOTICE OF CANCELLATION BE GIVEN FOR HYGIENE APPOINTMENTS AND 48 HOURS NOTICE OF CANCELLATION FOR ALL SURGICAL PROCEDURES OR YOU WILL INCUR A BROKEN APPOINTMENT FEE:

NAME _____ DATE _____

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HIPAA PRIVACY POLICY
POLICY AVAILABLE TO READ AT FRONT DESK UPON REQUEST

I, _____ hereby acknowledge that I have read and understand this practice's notice of privacy practices. I have been given the opportunity to ask any questions I may have regarding this notice.

_____
NAME

_____
DATE

- ❑ Individual refused to sign
- ❑ Communication barriers prohibited obtaining the acknowledgment
- ❑ An emergency situation prevented us from obtaining acknowledgment
- ❑ Other (please specify) _____

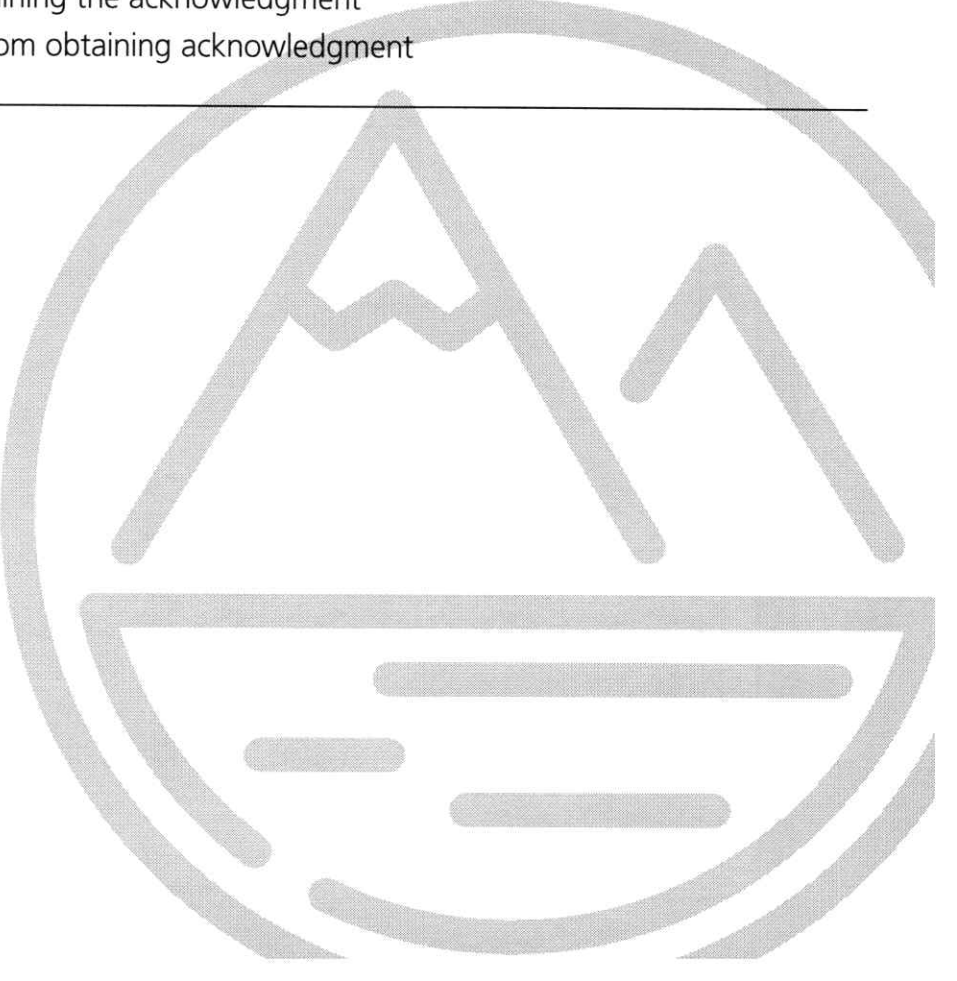

Photo Consent and Release Form

I do hereby agree to the following. I am allowing Dr. Saroj Saha and his team to take photos of my treatment and/or treated areas to be used for the purpose of monitoring my progress.

In addition:

I give permission for my photo to be used for education_____(please initial)

I give permission for my photos to be used for advertising_____(please initial)

At my request, my identity will remain anonymous_____(please initial)

At my request, my photos will only be used for my chart_____(please initial)

Print name_____

Signature_____ Date:_____