BRUCE EDELSTEIN DDS, PC

Today's Date: _____

Name: _____

I prefer to be called: _____

Home Address: _____

_____

Preferred Phone: (____)_____

Work Phone: (____)_____

Email Address: _____

Social Security Number: _____

Birthdate: _____

Male Female

Whom may we thank for referring you? _____

Other family members seen by us: _____

Employer: _____

Occupation: _____

SPOUSE OR SIGNIFICANT OTHER INFORMATION (IF INSURANCE SUBSCRIBER)

Spouse's Name: _____

Spouse's Employer: _____

Spouse's Social Security Number: _____

Spouse's Birthdate: _____

EMERGENCY CONTACT

Name: _____

Phone Number: _____

PHARMACY INFORMATION

Name: _____Number: _____

Address (PLEASE include zip code): _____

_____

WELCOME

BRUCE EDELSTEIN DDS, PC

# PATIENT HEALTH HISTORY

Your physician is_____ Physician number: _____

Your current age_____

*(Check all that apply)*

**HAVE YOU EVER HAD AN ADVERSE REACTION TO:**

☐ Local Anesthetics/Novocain ☐ Codeine ☐ Antibiotic _____

☐ Other_____ ☐ Any pain medication ☐ Latex

**DO YOU TAKE:**

☐ Blood thinners (e.g Coumadin, Plavix, etc.) *if yes*, date and score of most recent INR _____

☐ Any other medications, vitamins or supplements, if so, please list:

| Name of medication | What condition you take it for |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

*(List any additional meds you take on separate sheet)*

**WHAT IS YOUR LEVEL OF ANXIETY/STRESS/FEAR WHEN GOING TO THE DENTIST?** ☐ None ☐ Mild ☐ Mod ☐Severe

**ARE YOU SATISFIED WITH YOUR SMILE?** ☐ **YES** ☐ **NO** **WHY?**_____

**DO YOU HAVE TO AVOID EATING ANY FOODS BECAUSE OF YOUR TEETH?** ☐ **YES** ☐ **NO**

**OTHER MEDICAL CONDITIONS:** *(Check all that apply)*

☐ Asthma *if yes*, where do you keep your inhaler?_____

| | | | |
|---|---|---|---|
| ☐ Bleeding problems | ☐ Epilepsy | ☐ Prosthetic heart valve | ☐ Artificial joint |
| ☐ Hepatitis | ☐ Tuberculosis | ☐ HIV/AIDS | ☐ Thyroid Disease |
| ☐ Cancer | ☐ Chemo/radiation | ☐ Breathing Problems | ☐ Steroid Use |
| ☐ Kidney Problems | ☐ Psychiatric therapy | ☐ Change in health in last year | ☐ Any Addiction |
| ☐ Breathing/COPD | ☐ Vertigo | ☐ Hypertension | ☐ Congestive Heart Failure |
| ☐ Acid Reflux | ☐ Stroke | ☐ Mental disorder | ☐ HPV |

☐ Currently under care of physician? If so, why_____

**THE FOLLOWING RISK FACTORS MAKE IT MUCH EASIER FOR PERIODONTAL (GUM) DISEASE TO DEVELOP.**

*(Please check all of the risk factors that you have.)*

☐ Current Tobacco user → What kind_____ How much/day_____ For how long_____

☐ Previous Tobacco user → When did you quit_____

☐ Family history of gum disease (parents lost teeth at early age or gum disease on your side of family)

☐ Stress (d*eath of spouse, divorce/separation, death in family, injury/illness, retirement, loss of job, etc.)*

☐ Previous bouts of gum disease or gingivitis

☐ Spouse with gum disease (Gum disease may be transmissible, all family members should be screened for gum disease)

☐ Osteoporosis

☐ Taking Dilantin, Ca+ Channel Blockers, or Immunosuppressants for organ transplantation

☐ Alcohol or marijuana use

☐ Diabetes *(additional information requested on back)*

☐ Overweight *(additional information requested on back)*

☐ Poor nutrition *(additional information requested on back)*

**GUM DISEASE – HEART DISEASE**

Untreated gum disease can increase your risk for heart attack and stroke.

Have you been diagnosed with heart disease/stroke?

☐ Yes

☐ No → Do you have any of these risk factors?

☐Family history of heart disease ☐Tobacco use

☐High cholesterol ☐High blood pressure

**DIABETES**

Diabetics are more prone to gum disease. Left untreated, gum disease makes it harder for diabetics to control their blood sugar. Diabetics who have their gum disease treated can improve their blood sugar control thus making diabetic complications less likely.

Are you diabetic?

☐ NO → Any family history of diabetes? ☐ Yes ☐ No

Have any of these warning signs of diabetes?

☐ Frequent urination ☐ Excessive thirst/hunger

☐ Weakness/fatigue ☐ Slow healing of cuts

☐ Unexplained weight loss

☐ YES → How is your diabetes control? ☐Good ☐Fair ☐Poor

Date of last A1c_____What score?_____

Who is your diabetes Doctor_____

**OBESITY**

Being overweight increases your risk for gum disease. Obesity and gum disease are both risk factors for heart disease and diabetes. Thus, if you are at less than ideal weight it is vitally important for you to eliminate any gum inflammation to lower your risks for more serious health problems.

We can calculate your weight status by using Body Mass Index (BMI)

List your current weight_____

List your current height_____

BM I=(703 x weight)/ (height)$^2$

| | |
|---|---|
| 18.4 or below | Underweight |
| 18.5 to 24.9 | Healthy weight |
| 25.0 to 29.9 | Overweight |
| ≥30.0 | Obese |

Do you find it hard to eat a balanced diet? ☐ Yes ☐ No

Have you ever had your Vitamin D level checked? ☐ Yes ☐ No

**RHEUMATOID ARTHRITIS**

If you have rheumatoid arthritis, emerging research suggests that eliminating any gum disease and then keeping it at bay can lessen the crippling effects of arthritis.

Have you ever been diagnosed with Rheumatoid Arthritis?

☐ Yes ☐ No

**ALZHEIMER'S DISEASE**

Research suggests that patients with long standing gum disease may be more likely to develop adverse mental decline as they age.

Do you have a family history of Alzheimer's Disease?

☐ Yes ☐ No

**FEMALES**

Are you: ☐ Pregnant ☐ Nursing ☐ Taking birth control pills

Are you post-menopausal? ☐ Yes ☐ No

Do you have osteoporosis?

☐ Yes

☐ No → Have you ever been tested for osteopenia/porosis? ☐ Yes ☐ No

Do you have any of the following risk factors for osteoporosis? ☐ Yes ☐ No

*Post-menopausal* *Family history of osteoporosis* *Early menopause*

*Rheumatoid Arthritis* *Inadequate exercise* *Tobacco use/Smoking*

Ever taken *Fosamax, Fosamax Plus D, Actonel, Boniva, Didronel, Skelid, Aredia, Bonefors*, or *Zometa* for osteoporosis or for any other reason? ☐ Yes ☐ No

**SIGNATURE**_____ **DATE**_____

# Bruce A. Edelstein, DDS, PC

## CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

**SECTION A: PATIENT GIVING CONSENT**

Name: See Chart

Address:

Telephone: E-mail:

Patient #: Social Security #:

**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.**