Warren C. Baine, D.M.D.

Patient Health Record

The following information is requested to assist the Doctor in administering the proper dental service. Please answer to the best of your ability.

NAME (last)_____(first)_____(middle)_____

HOME ADDRESS_____

BUSINESS ADDRESS_____

PHONE (home)_____(business)_____(cell)_____

DATE OF BIRTH_____Sex_____MARITAL STATUS (circle) S M W D_____

OCCUPATION_____SOCIAL SECURITY NUMBER_____

TYPE OF DENTAL INSURANCE_____REFERRED BY_____

SPOUSE'S NAME_____SOCIAL SECURITY NUMBER_____

SPOUSE'S DATE OF BIRTH_____Reason for your visit_____

Emergency information – Name, address and telephone number of an individual we can call.

MEDICAL HEALTH General Health (please circle) Excellent Good Fair Poor

Name, address & telephone number of your physician_____

Last complete physical?_____ Are you taking any medications now? Yes No

If yes, please list all medications_____

Have you ever taken Fosomax, Novartis, Zometa,Aredia, or related medications for Osteoporosis? Yes____ No____

Are you allergic to: Antibiotics Codeine Aspirin Local anesthetics Other_____

Do you take Aspirin on a regular basis? Yes____ No____

Do you smoke cigarettes? Yes How many per day?_____ No

Have you ever been hospitalized? Yes No If so give date and reason_____

Are you taking any vitamin supplements? Yes No Are you on an aspirin regimen? Yes No

Is your blood pressure Normal Low High Have you experienced any recent weight change?_____

Do you consume alcohol on a daily basis? Yes No

WOMEN: Are you pregnant? Yes How long?_____ No

Are you taking birth control pills? Yes No Do you anticipate becoming pregnant in the near future? Yes No

Have you been tested for Hepatitis? Yes No

Have you had any blood transfusions? Yes No

Are you being treated with immunosuppressive drugs? Yes No

Do you have a history of cold sores, fever blisters or canker sores? Yes No

PLEASE NOTE, THERE WILL BE A CHARGE FOR APPOINTMENTS CANCELLED WITHOUT 24 HOURS NOTICE.

-OVER-

Do you have or have you ever been informed that you had any of the following? (please circle)

Chest pains	Glaucoma	Thyroid problems
Heart disease	Hormonal problems	Ulcers
Tuberculosis or Lung disease	Cancer or Leukemia	Anemia
Diabetes	Psychiatric problems	Aids
Hypertension	Allergies or Hives	Artificial joints
Heart murmur	Congenital heart defects	Stroke
Rheumatic fever	Epilepsy or Seizures	Enlarges lymph nodes
Unexplained fevers	Persistent diarrhea	
Bluish-Reddish Lesions		
Hemophilia	Kidney problems	Night sweats
Prosthetic Valves or Joints	Fatigue	Sickle cell disease
Prolonged sore throat	Prolonged bleeding problems	Persistent cough
Bruise easily	Genetic problems	Jaundice
Excessive urination &/or Thirst	Sinus trouble	Asthma
Postural hypertension (fainting spells)	Sexually transmitted disease (Gonorrhea, Syphilis, Genital herpes)	

Other condition or problem not listed_____

DENTAL HEALTH
(please circle)
When was your last dental visit?_____Have you ever had a problem associated with dental care? Yes No
How often do you brush your teeth?_____What texture brush? Soft Medium Hard

How often do you floss?_____ Do your gums bleed during brushing or flossing? Yes No
Do your gums feel tender or swollen? Yes No Does food catch between your teeth? Yes No
Do you chew only on one side of your mouth? Yes No Does your jaw ever feel tired? Yes No
Do you wear full or partial dentures? Yes No Do you gag easily? Yes No
Are you nervous about your dental treatment? Yes No
If yes, have you had Nitrous Oxide Yes No Medication prior to treatment Yes No
Do you feel pain when your teeth come in contact with hot, cold, sweet or sour? Yes No

PAYMENT IS EXPECTED AT THE TIME OF VISIT

Name of person responsible for payment:_____(only if different than signee below)

I understand that the health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I clearly understand and agree to services rendered me are charged directly to me and that I am personally responsible for payment. I also agree that if I suspend or terminate my care and treatment for services rendered me will be immediately due and payable. Additionally it is agreed that should the fee for the professional services not be paid in accordance with the provisions herein, there shall be included in the computation of the amount due, reasonable attorney's fees in the sum of 33% of the total amount due, plus applicable finance charges and disbursements, allowances and costs provided by law. Accounts requiring additional statements due to excessive lateness are liable for a $10 billing fee each month. Finance charges can be applied to all past due amounts at the rate of 1.5% per month. If account is in default and turned over for collection, a collection fee will be added. The undersigned also hereby authorizes the Doctor to perform all the necessary diagnostic procedures deemed appropriate to make a thorough diagnosis of the patient's dental or oral-facial needs including x-rays, study models, photographs, medications, and the use of local anesthetic agents. **I hereby acknowledge that I have been given the opportunity to review or, if requested have received a copy of this practice's Notice of Privacy Practices. I have been given the opportunity to ask any questions I may have regarding this notice.**

Patient's Signature:_____Date:_____

Guardian or Spouse's Signature:_____Date_____

Doctor's Signature:_____Date:_____

24-16 Queens Plaza South Long Island City, NY 11101 718 784 1741

PERIODONTAL TREATMENT (non-surgical)

About the proposed treatment

Non-surgical periodontal treatment involves thoroughly cleaning your teeth in the office to help heal inflamed or infected gum tissue. Treatment involves removing the bacterial substance known as plaque and harder mineral deposits called calculus from tooth surfaces above and below the gumline (this is called **scaling**). It may also involve smoothing the roots of your teeth (called **root planing**). It may also involve washing the root surfaces of the teeth with a disinfecting and/or desensitizing solution. (called **irrigation or desensitization**)

Your condition will be monitored through regular examinations of your teeth and gums and measurement of the pockets that have formed in the gums surrounding your teeth. Dental x-rays will be taken to check the condition of the roots of your teeth and the bone that supports your teeth. You may also receive medications or a special mouthrinse to help control the growth of bacteria that accumulate around your teeth and cause inflammation and infection of gum tissues.

You will also be taught the proper methods for caring for your teeth at home. The success of this treatment depends in part on your efforts to brush and floss daily, receive regular cleaning as directed, follow a healthy diet, avoid tobacco products and follow other recommendations.

Benefits and alternatives

Regular, professional cleanings help to create a clean environment in which your gums can heal. They also reduce the chances of further irritation and infection by making it easier for you to keep your teeth clean. Depending on the success of these treatments, surgical methods may also be prescribed to help control gum disease.

Depending on the seriousness of your current condition, existing medical problems or medications you may be taking, these methods alone may not completely reverse the effects of gum disease or prevent further problems in the future.

Common risks

1. Bleeding, swelling, soreness and infection: During and shortly after treatment, your gums may bleed, swell or feel sore, which may be treated with pain medication. Because cleanings involve contact with bacteria and infected tissue in your mouth, you may also experience an infection, which would be treated with antibiotics.

2. Reaction to anesthesia and/or sedation: To keep you more comfortable during treatment you may receive a local anesthetic and possibly a sedative (tranquilizer). In rare instances patients have an allergic reaction to the anesthetic, which may require emergency medical attention, or find that it reduces their ability to control swallowing, which increases the chance of swallowing foreign objects during treatment. Sedatives may temporarily make you drowsy or reduce your coordination.

3. Hot and cold sensitivity: As your gum tissues heal, they may shrink somewhat, exposing some of the root surface. This could make your teeth more sensitive to hot or cold.

4. Stiff or sore jaw joint: Holding your mouth open during treatment may temporarily leave your jaw feeling stiff and sore and may make it difficult for you to open your mouth wide for several days afterwards. Treatment may leave the corners of your mouth red or cracked for several days.

Consequences of not performing treatment

This course of treatment will help to improve your condition and prevent this disease from spreading. If you received no treatment or ongoing treatment were interrupted or discontinued, your condition would continue and probably worsen. This could lead to further inflammation and infection of gum tissues, tooth decay above and below the gumline, deterioration of bone surrounding the tooth and eventually, the loss of teeth.

Additional information:

_____

_____

Approximate Cost: Total per Quadrant_____ Estimated Out of Pocket per Quadrant_____

Every reasonable effort will be made to ensure that your condition is treated properly, although it is not possible to guarantee perfect results. By signing below, you acknowledge that you have received adequate information about the proposed treatment, that you understand this information and that all of your questions have been answered fully.

___ I give my consent for the proposed treatment as described above.

___I understand that _____is an additional cosmetic or functional procedure that is not covered by my insurance. The additional cost of this optional procedure will be fully my responsibility and ***not*** my insurance company even though our practice may participate with your insurance coverage.

___ I refuse to give my consent for the proposed treatment as described above. I have been informed of the potential consequences of my decision to refuse treatment.

_____

Patient's signature/Date

_____

Witness's signature/Date