WEST VALLEY IMPLANT DENTAL PRACTICE
Alfred Penhaskashi, D.D.S.
PRACTICE LIMITED TO PERIODONTICS AND DENTAL IMPLANTS
5363 BALBOA BLVD., SUITE 226., ENCINO, CA 91316 TEL (818) 788-7091 FAX (818) 788-8876

Patient Registration Form

On behalf of our office we would like to welcome you as a patient. You have been referred to us because your dentist has advised you that you may have periodontal disease. Your initial visit to our office will consist of a complete periodontal examination. In order for us to begin this evaluation, please complete the information on this sheet as completely as you can. Thank you.

PATIENT INFORMATION

NAME: ______________________________

SEX: __________ BIRTHDATE: ______________

SOCIAL SECURITY #: ______________________

ADDRESS: ______________________________

CITY: ______________ STATE: _____ ZIP: _______

HOME PHONE: __________ CELL PHONE:__________

EMAIL ADDRESS: __________________________

EMPLOYED BY: ____________________________

ADDRESS: ____________ PHONE: ____________

DENTIST WHO REFERRED YOU: ________________

MARITAL STATUS

SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐

COMPLETE BELOW IF APPLICABLE

SPOUSE NAME: ____________________________

EMPLOYER: _______________________________

EMPLOYER ADDRESS: _______________________

POSITION: _______________________________

SSN: ______________ BIRTH DATE: __________

IN CASE OF EMERGENCY NOTIFY - NAME, RELATIONSHIP, PHONE:

____

____

____

DENTAL INSURANCE 1ST COVERAGE

EMPLOYEE NAME: __________________________

SSN: ______________ DOB: __________

EMPLOYER: _______________________________

EMPLOYER ADDRESS/PHONE: _________________

____

INS COMPANY: ____________________________

INS. CO. ADDRESS: ________________________

____

INS. CO. PH #: __________ GROUP#: ________

DENTAL INSURANCE 2nd COVERAGE

EMPLOYEE NAME: __________________________

SSN: ______________ DOB: __________

EMPLOYER: _______________________________

EMPLOYER ADDRESS/PHONE: _________________

____

INSURANCE COMPANY: ______________________

INS. CO. ADDRESS: ________________________

____

INS. CO. PH #: __________ GROUP#: ________

I authorize release of any information relating to my treatment or insurance claims. I consent to examination and any initial treatment necessary.

I hereby authorize payment directly to the provider periodontist of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental care. This office will help prepare the patients insurance forms to assist in making collections from insurance companies and will credit such collections to the patients account. However, this dental office cannot render service on the assumption that our charges will be paid by the insurance company. For our patients with Dental Insurance (indemnity), we request that deductibles and patient portion that is not paid by your Insurance be paid at the time service is rendered.

I understand that 24-hour notice is required for cancellation of routine appointments (48 hours for surgical appointments) or a broken appointment fee will be charged. Dental office will charge $100.00 for each one hour missed appointment time when less than 24 hour notice is given and this amount must be paid before any further care is rendered.

I GIVE CONSENT TO THE DENTAL PRACTICE OF ALFRED PENHASKASHI, D.D.S., INC. TO USE MY CELL PHONE NUMBER OR EMAIL TO CONTACT OR TEXT ME REGARDING APPOINTMENTS, TREATMENT, INSURANCE OR MY ACCOUNT. I UNDERSTAND THAT I CAN WITHDRAW MY CONSENT AT ANY TIME.

______________________________________ ____________________

SIGNATURE (PATIENT, PARENT OR GUARDIAN) DATE

HEALTH HISTORY

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.

Name: ______________________ Birth Date: ______________ Age: ________

Please answer each question. CIRCLE YES or NO. If in doubt, leave blank.

1. Are you in good health?.. Yes No
2. Are you now under the care of a physician?.. Yes No
   If yes, what is the condition being treated?______________________
3. Have you ever been hospitalized or had a serious illness?.. Yes No
   If yes, explain ______________________
4. Have you ever had excessive bleeding following an extraction, or do cuts take longer to heal?.. Yes No
5. Do you use tobacco in any form? If yes, how much ______________________ Yes No
6. Do you use alcoholic beverages (more than 2 drinks per day)?.. Yes No
7. Are you pregnant? .... Yes No
   Estimated delivery date______________________

Do you have or have you ever had any of the following? (PLEASE CIRCLE EACH RESPONSE)

Tire easily, weakness	Yes	No	Heart murmur/Mitral Valve problem	Yes	No
Marked weight change	Yes	No	Chest pain/discomfort	Yes	No
Night sweats	Yes	No	Heart problems	Yes	No
Persistent fever	Yes	No	Shortness of breath	Yes	No
Frequent nosebleeds	Yes	No	Swelling ankles	Yes	No
Sinus problems	Yes	No	High blood pressure	Yes	No
Sore throat/hoarseness	Yes	No	Congenital heart disease	Yes	No
Stroke	Yes	No	Artificial Heart valve	Yes	No
Headaches	Yes	No	Pacemaker	Yes	No
Convulsions/epilepsy	Yes	No	Heart surgery	Yes	No
Numbness/tingling	Yes	No	Arthritis/rheumatism	Yes	No
Psychiatric treatment	Yes	No	Artificial joints	Yes	No
Tuberculosis	Yes	No	Hepatitis, other liver disease	Yes	No
Emphysema	Yes	No	Jaundice	Yes	No
Asthma/hay fever	Yes	No	Ulcers, stomach problems	Yes	No
Persistent cough	Yes	No	Venereal disease	Yes	No
Sputum production (phlegm)	Yes	No	Bruise easily	Yes	No
Cough up bloody sputum	Yes	No	Anemia	Yes	No
Difficulty breathing	Yes	No	Blood transfusion	Yes	No
Diabetes	Yes	No	Radiation therapy	Yes	No
Family history of diabetes	Yes	No	Tumors or growths	Yes	No
Thyroid condition/goiter	Yes	No	Cancer	Yes	No
Rheumatic fever	Yes	No	AIDS	Yes	No
Ever taken Phen-Fen	Yes	No	HIV positive	Yes	No
Skin disease	Yes	No	Herpes	Yes	No

Are you allergic to or have experienced any reaction to the ff?			**Are you taking any of the following:**		
Local anesthetics (novocaine)	Yes	No	Antibiotics/sulfa drugs	Yes	No
Barbiturates/sedatives	Yes	No	Blood thinners	Yes	No
Sleeping pills	Yes	No	Blood pressure medication	Yes	No
Penicillin/other antibiotics	Yes	No	Thyroid medicine	Yes	No
Aspirin or Codeine	Yes	No	Cortisone/steroids	Yes	No
Sulfa drugs	Yes	No	Antihistamines/allergy drugs	Yes	No
Other allergies	Yes	No	Tranquilizers	Yes	No
Erythromycin	Yes	No	Insulin/other diabetic drugs	Yes	No
Latex	Yes	No			

Are you taking any of the following?

Recreational drugs	Yes	No	Nitroglycerin	Yes	No
Digitalis/other heart meds	Yes	No	Aspirin	Yes	No

Are you taking any form of bisphosphonates or Fosomax? ______________________________

Are you taking any other Medications? ______________________________

If yes to any of the above, list name of medications and dosage below:

1. ______________________________ 3. ______________________________

2. ______________________________ 4. ______________________________

Is there a disease, condition or problem not listed above that you think we should know about, or is there any activity your doctor says you cannot do? If so, explain ______________________________

____

Physician's Name ______________________________ **Physician's Phone**______________________________

DENTAL HISTORY

Have you ever had any serious trouble associated with previous dental treatment? ______________________________

____

Initial Complaint ______________________________

Does dental treatment make you nervous? No _______ Slightly ______ Moderately ______ Extremely ________

Date of last dental visit ______________________________

Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth), with treatments such as Scale, Root Planing, Deep Cleaning, or Surgery? ______________________________

If so, when? ______________________________

Do you have or have you ever had any of the following?

Bleeding, sore gums	Yes	No	Loose teeth	Yes	No
Unpleasant taste/bad breath	Yes	No	Sensitive to hot or cold	Yes	No
Burning tongue/lips	Yes	No	Sensitive to sweets	Yes	No
Frequent blisters, lips/mouth	Yes	No	Sensitive to biting	Yes	No
Swelling/lumps in mouth	Yes	No	Food impaction	Yes	No
Ortho treatments (braces)	Yes	No	Clenching/grinding	Yes	No
Biting cheeks/lips	Yes	No	Shifting of teeth	Yes	No
Clicking/popping jaw	Yes	No	Change in bite	Yes	No
Difficulty opening/closing jaw	Yes	No	Allergy to metals	Yes	No
Cold sores	Yes	No			

Do you use the following?

Brush	Yes	No
Dental Floss	Yes	No
Fluoride Rinse	Yes	No

How often do you brush? ______________

Brush is ( ) Soft ( ) Hard ( ) Medium

Has there any been any changes to your medical history?______________________________

When was the last time you saw your dentist and had xrays? ______________________________

Any concern you might have that you would like the hygienist and Dr.Penhaskashi to take a look at? __________________

Is there anything else we can do to make your visit exceptional? ____

____

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. I also authorize the dental office to contact my prior dental and/or medical office for any records and/or x-rays that may be necessary to render treatment.

Signature of patient,
parent or guardian ____ Date____________________

Dentist Signature ____ Date____________________

Alfred Penhaskashi, D.D.S. Inc

HIPAA - Patient Consent of Information

The office of Dr. Alfred Penhaskashi, in order to comply with the HIPAA Privacy Regulation, requires an authorization from the patient before detailed messages are left for the patient. This policy is to protect the privacy of the patient and to protect the physicians and staff of Dr. Alfred Penhaskashi from violating the patient' s confidentiality. If there is not a signed consent on file, physicians and staff will only leave their name and telephone number on an answering machine, voicemail or with a live person answering the phone requesting the patient to return the call.

By completing the consent below, you are allowing Dr. Alfred Penhaskashi's physicians and its staff to leave a message on an answering machine, voicemail or with a specified individual. You may specify what information is left and with whom by noting the information on the bottom of this form. By signing, you are also consenting to the mailing or faxing of any results, requested by you, to your primary care physician or another physician involved in your care.

I give my consent to Dr. Alfred Penhaskashi and staff to leave a message regarding scheduling, treatment, surgery, lab or radiology results, or other information as necessary (check all that apply):

_____ via text message
_____ on an answering machine or voicemail at home or cell phone
_____ on an answering machine or voicemail at work
_____ with_________________________relationship_______________
_____ with_________________________relationship_______________

_____ I do not consent to messages being left at home, work or with any other person. I wish to be contacted directly

________________________________ ________________
Patient's Name (Please Print) Date of Birth

________________________________ ________________
Patient's Signature Date

________________________________ ________________
Witness Date

HIPAA – Notice of Privacy Practice Acknowledgement

_____I have been provided a copy of Dr. Alfred Penhaskashi's Notice of Privacy Practice.

_____I have declined a copy of Dr. Alfred Penhaskashi Notice of Privacy Practice.

________________________________ ________________
Patient's Signature Date