Patient Information Sheet

Chart# _____ Date _____

PATIENT

First Name: _____ Last Name: _____ Int. _____ Sex: Male/Female

Address: _____ Apt# _____

City: _____ State: _____ Zip: _____

Home Phone (____) _____ Work Phone: (____) _____ ext: _____

Soc Sec# _____ DL# _____ Date of Birth: _____ Age: _____

RESPONSIBLE PARTY (IF NOT PATIENT)

First Name: _____ Last Name: _____ Int. _____ Sex: Male/Female

Address: _____ Apt# _____

City: _____ State: _____ Zip: _____

Home Phone (____) _____ Work Phone: (____) _____ ext. _____

Soc Sec# _____ DL# _____ Date of Birth: _____ Age: _____

Relationship to Patient: _____

EMPLOYMENT & CREDIT INFORMATION (____ Patient ____ Responsible Party)

Employer: _____ Position: _____

Address: _____ How Long? _____

City _____ State: _____ Zip: _____

HOME: _____ Owned _____ Rent How long? _____

Previous Address: _____

I am aware that by signing below I certify that all information is complete and correct. Emmanuel N. Pacia, D.D.S. may verify this information from which ever sources it deems necessary (including but not limited to credit reports) and may provide others with information regarding your credit history (or the credit report) to the extent permitted by law. This is your authorization for Emmanuel N. Pacia, D.D.S. to verify credit history.

_____ Signature of Patient

_____ Signature of Responsible Party

TO BE COMPLETED BY OFFICE STAFF ONLY

COVERAGE: _____ DENTI-CAL _____ INSURANCE _____ CASH _____ PREPAID _____

Pre Paid Plan or Insurance Carrier _____ Plan # or Policy# _____

Procedure _____ Coverage or Liability Verified by _____

Employment Verified by _____ Approved by: _____ Date: _____

HEALTH HISTORY
HISTORIA DE SALUD

PATIENT NAME _____ NOMBRE DEL PACIENTE _____

CHART NO. _____ OFFICE _____ DATE _____

Date of Birth _____ Sex _____ Height _____ Weight _____

INSTRUCTIONS

Answer all questions and fill in blank spaces when indicated. Answers to the following questions are for our records only and will be confidential.

INSTRUCCIONES

Conteste todas las preguntas y llene los espacios en blanco cuando se indique. Las contestaciones a nuestras preguntas son unicamente para nuestros archivos, y se consideran estrictamente confidenciales.

	YES/SI	NO
1 Are you in poor health	____	____
2 Has there been any change in your general health within the past year	____	____
3 My last physical was on _____		
4 Are you now under the care of a physician	____	____
A. If so, what is the condition being treated _____		
5 The name and address of my physician is _____		
6 Have you had any serious illness or operation	____	____
A. If so, what was the illness or operation _____		
7 Have you been hospitalized or had a serious illness within the past five years	____	____
A. If so, what was the problem _____		
8 Do you have or have you had any of the following diseases or problems:		
A. Damaged heart valves or artificial heart valves	____	____
B. Congenital heart lesions or murmurs	____	____
C. Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke)	____	____
1) Do you have pain in chest upon exertion	____	____
2) Are you ever short of breath after mild exercise	____	____
3) Do your ankles swell	____	____
4) Do you get short of breath when you lie down, or do you require extra pillows when you sleep	____	____
5) Do you have a cardiac pacemaker	____	____
D. Allergy	____	____
E. Sinus trouble	____	____
F Asthma	____	____
G. Hives or skin rash	____	____
H. Fainting spells or seizures	____	____
I Diabetes		
1) Do you have to urinate (pass water) more than 6 times a day	____	____
2) Are you thirsty much of the time	____	____
3) Does your mouth frequently become dry	____	____
J. Hepatitis, jaundice or liver disease	____	____
K. Arthritis	____	____
L. Inflammatory rheumatism (painful, swollen joints)	____	____
M. Stomach ulcers	____	____
N. Kidney trouble	____	____
O. Turberculosis	____	____
P Do you have a persistent cough or cough up blood	____	____
Q. Low blood pressure	____	____
R. Venereal disease	____	____
S. Do you have prosthetic hip or joint prosthesis, implants, bone plates or screws	____	____
If so, what _____		
9. Have you had abnormal bleeding associated with previous extractions, surgery, or trauma	____	____
A. Do you bruise easily	____	____
B Have you ever required a blood transfusion	____	____
If so, explain the circumstances _____		
10. Do you have any blood disorder such as anemia	____	____
11 Have you had surgery or x-ray treatment for a tumor, growth, or other condition of your mouth or lips	____	____
12. Are you taking any drug or medicine	____	____
If so, what _____		

1. Esta mal de salud	
2. Ha habido cambio de su salud durante el último año pasado	
3. Mi ultimo examen medico fue en _____	
4 Esta ahora bajo atencion medica	
A. Si es asi, que enfermedad se esta curando _____	
5 El nombre y domicillo de mi medico es _____	
6. Ha tenido alguna enfermedad seria u operation	
A. Si es asi, que enfermedad o operacion _____	
7. Durante los ultimos cinco (5) años ha sido hospitalizado o tenido una enfermedad seria	
A. Si contesta afirmativamente explique _____	
8. Tiene o ha tenido alguna de las siguientes enfermedades o problemas:	
A. Valvulas del corazon danadas o valvulas artificiales del corazon	
B. Lesion cardiaca congénita	
C. Enfermedad cardiovascular (enfermedad del corazon insuficiencia cardiaca, oclusion coronaria, alta presion arterial, arteriosclerosis, sincope)	
1) Tiene algun dolor en al pecho cuando hace algun esfue	
2) Despues de hacer algun ejercicio siente faltar e en a	
3) Se le hinchan los tobillos	
4) Cuando se acuesta siente que le falta aire para resp o le faltan mas almohadas cuando duerme	
5) Tiene un marcapasos cardiaco	
D. Alergia	
E. Problema de sinusitis	
F. Asma	
G. Ronchas o sarpullido	
H. Desmayos y sudores o ataques	
I. Diabetis	
1) Orina usted mas de seis veces por dia	
2) Tiene sed la mayoria del tiempo	
3) Se le reseca la boca frecuentemente	
J. Malestar bilioso, hepatitis o enfermedad del higado	
K. Artritis	
L. Inflamacion reumatica (coyunturas inflamades con dolor	
M. Ulceras estomacales	
N. Enfermedad del riñon	
O. Turberculosis	
P. Tos persistente o tose sangre	
Q. Baja presion sanguinea	
R. Enfermedades venereas	
S. Tiene cadera o cojuntura prosthetica, implantes p de hueso or tornillos	
Si es asi, que _____	
9. Ha sangrado anormalmente, cuando una extraccion dental cirujia o trauma	
A. Se moretea su piel facilmente	
B. Ha requerido transfusion sanguinea	
Si contesta afirmativamente explique _____	
10. Tiene algun desorden sanguineo tal como anemia	
11. Ha tenido cirujia o rayos x para tratar algun tumor crecimiento u otra enfermedad bucal or labial	
12. Esta tomando alguna droga o medicina	
Si es asi, que esta tomando _____	

	YES/SI	NO		
13 Are you taking any of the following:				13. Está tomando alguno de los siguientes medicamentos
A. Antibiotics or sulfa drugs	____	____		A. Sulfas o antibioticos
B. Anticoagulants (blood thinners)	____	____		B. Anticoagulantes (adelgazador sanguineo)
C. Medicine for high blood pressure	____	____		C. Medicamento contra la alta presion
D. Cortisone (steroids)	____	____		D. Cortisona (esteroides)
E. Tranquilizers	____	____		E. Tranquilizantes
F. Antihistimine	____	____		F. Antihistaminico
G. Aspirin	____	____		G. Aspirina
H. Insulin, tolbutamide (orinase) or similar drug	____	____		H. Insulina, tobultamida (orinase) o drogas similares
I. Digitalis or drugs for heart trouble	____	____		I. Digitales o medicamentos para enfermedades cardiacas
J. Nitroglycerin	____	____		J. Nitroglicerina
K. Oral contraceptive or other hormonal therapy	____	____		K. Anticonceptivos orales o otra terapia hormonal
L. Other_____				L. Otro _____
14. Are you allergic or have you reacted adversely to:				14. Es usted alergico o ha reaccionado adversamente a los siguientes medicamentos:
A. Local anesthetics	____	____		A. Anestesia local
B. Penicillin or other antibiotics	____	____		B. Antibioticos o penicilina
C. Sulfa drugs	____	____		C. Drogas con sulfas
D. Barbiturates, sedatives or sleeping pills	____	____		D. Barbituricos, sedantes o pastillas para dormir
E. Aspirin	____	____		E. Aspirina
F. Iodine	____	____		F. Yodo
G. Codeine or other narcotics	____	____		G. Codeina o otros narcoticos
H. Are you alergic to latex or rubber products	____	____		H. Es usted alergico a látex o productos de hule
I. Other_____				I. Alguna otra_____
15. Have you had any serious trouble associated with any previous dental treatment	____	____		15. Ha tenido algun problema despues de haber tenido un tratamiento dental
If so, explain _____				Si es asi explique _____
16. Do you have any disease, condition, or problem not listed above that you think I should know about	____	____		16. Tiene usted alguna enfermedad o condicion fisica o algun problema no enumerado anteriomente y que usted crea que yo deba saber
If so, please explain_____				Si es asi explique _____
17. Are you employed in any situation which exposes you regularly to x-rays or other ionizing radiation	____	____		17. Esta trabajando o esta en un situación donde esta expues regularmente a radiografias o algun otra forma de radiacion
18. Are you wearing contact lenses	____	____		18. Esta usando lentes de contacto
19. Have you been in sexual contact with anyone at risk for the following:	____	____		19. Ha estado en sexual contacto con alguien con lo siguiente:
A. Herpes C. TB				A) Herpes C) Tuberculosis
B. Hepatitis D. AIDS				B) Hepatitis D) CIDA
20. Are you pregnant	____	____		20. Esta usted encinta
21. Do you have any problems associated with your menstrual period	____	____		21. Tiene algun problema asociado con su periodo menstrual
22. Are you nursing	____	____		22. Esta dando pecho (amamamtar)
23. When was your last vist to the Dentist _____				24. Cuando fue su ultima visita al dentista

Follow up to Medical History DDS Only

UPDATE TO MEDICAL HISTORY

DATE	COMMENTS	SIGNATURE OF PATIENT OR PARENT IF PATIENT IS A MINOR	DDS INITIAL

I hereby certify that I have read the forgoing and have filled out this health questionnaire completely. I have advised you of all medical problems of which I am aware. I further certify that I, the undersigned, consent to the performing of x-rays, examination and whatever dental treatment may be agreed upon to be necessary or advisable.

Yo por la presente he leido lo de arriba y he contestado este cuestionario de salud total mente. He dado a conocer todos los trastomos de que tengo concocimieto. Ademas certifico que yo, el que firma, presto mi concentimento para que hagan el uso de rayos X, examinacon o cualquier tratamieto dental que sea de acuerdo o aconcejado.

SIGNATURE OF PATIENT OR PARENT IF PATIENT IS A MINOR _____ DATE _____

FIRMA DEL PACINTE SI MENOR FIRME PADRE _____ FECHA _____

SIGNATURE OF DOCTOR (Firma del Doctor) _____ DATE (Fecha) _____

EMMANUEL N. PACIA D.D.S.
16905 SAN FERNANDO MISSION BLVD.
Granada Hills, CA 91344

PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this _____ day of _____, 20___.

Print Patient Name: _____

Relationship to Patient: _____

Signature: _____

PACIA DENTAL CORPORATION

Dr. Emmanuel N. Pacia
16905 San Fernando Mission Blvd
Granada Hills, CA 91344
Phone (818) 368-4661
Fax (818) 368-1344
epacia818@aol.com

TO ALL PATIENTS WITH INSURANCE COVERAGE

PLEASE READ AND SIGN

If you have an insurance coverage, it is your responsibility to know the policy and guidelines of that company. What that means is, you are responsible to know your deductible, co-pay, type of coverage, your benefits and whether or not you need authorization to be seen at the office.

IMPORTANT! If we are an out-of-network provider for your insurance please know that your insurance coverage is different than going to an in-network provider.

With so many insurance policies around: it is virtually impossible for this office to know the details of every insurance policy. We will try to help you as much as possible, but should your insurance deny your bill, you will be liable for any charges.

If you have any questions, we will be happy to answer and assist you in anyway.

Thank you.

_____

PRINT Patient's Name

_____ _____

Patient's or Responsible Party's Signature **Date**

PACIA DENTAL CORPORATION
16905 San Fernando Mission Blvd.
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Tel. (818) 368-4661 Fax (818) 368-1344

BROKEN APPOINTMENT AGREEMENT

In the interest of your good health, our office will reserve appropriate time for your appointment schedule. The Doctor may dedicate himself or herself to your quality care.

In the event that you are not able to keep the scheduled appointment, we ask that you notify our office at least 24 hours in advance. Broken appointments not only delay your necessary treatment, but also deny other patients the opportunity for treatment.

For this reason, there may be a fee of $25.00 for late, broken or failed appointments.

PATIENT'S SIGNATURE DATE
Or Parent if Patient is a Minor