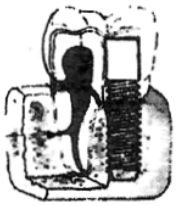

SCOTT D. SAZIMA D.D.S.

PRACTICE LIMITED TO PERIODONTICS
26032 Detroit Road • Westlake, Ohio 44145
(440) 835-4600

Part 1: PATIENT INFORMATION

Name_____ Address_____ E-Mail _____

City_____ State_____ Zip_____ Birth Date_____ Sex _____

Home Phone_____ Work Phone_____ Employer_____

Soc. Sec. #_____ Spouse's Name_____ Student? ____ If yes, which school?_____

Cell Phone _____ Emergency Contact (Other than residence)_____ Relation _____

Part 2: INSURANCE INFORMATION

If you would like to use your dental insurance, please fill out the following and sign:

Insured's Name_____ Insured's Soc. Sec. # _____ Insurance Co. _____

Insured's relationship to patient _____ Insured's date of birth _____ Insured's Employer_____

Signature _____ Date _____

Payment is expected at the time services are rendered. We accept cash, MasterCard, Visa, Discover, debit cards, and dental insurance. We also have a credit card plan available. If you would like to apply for that, please let us know!!!

Part 3: DENTAL QUESTIONS

How can we help you? _____ How did you hear about our office? _____

If you found our office on the internet, what category, terms and words did you search under? _____

Were you satisfied with your past dental treatment? _____ If not, why? _____

How would you describe a good dentist? _____

Are you pleased with the appearance of your teeth? Yes / No If no, what would you change? _____

Would you like whiter teeth? Yes / No Do your gums ever bleed? Yes / No

Do you snore or have sleep apnea? Yes / No Have you ever received treatment/appliances for this issue?

_____

_____

How would you describe your present dental health? _____

_____

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

As a result of the Health Insurance Portability and Accountability Act (HIPAA) enacted on April 14, 2003, all healthcare offices are required to inform patients of their privacy policy. This office's privacy policy is posted on the wall in the reception area.

I acknowledge that I have been informed of this office's privacy practices. I understand that I may request a copy of these practices at any time.

SIGNATURE_____ **DATE**_____

Time 5:06 PM

Westlake Periodontics

Eaglesoft Medical History

Date 7/27/2017

Patient Name:

Birth Date:

Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	Yes	No	If yes
Have you ever been hospitalized or had a major operation?	Yes	No	If yes
Have you ever had a serious head or neck injury?	Yes	No	If yes
Are you taking any medications, pills, or drugs?	Yes	No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	Yes	No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes	No	If yes
Are you on a special diet?	Yes	No	
Do you use tobacco?	Yes	No	
Do you use controlled substances?	Yes	No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic

☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other? If yes

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

AIDS/HIV Positive	Yes	No	Cortisone Medicine	Yes	No	Hemophilia	Yes	No	Radiation Treatments	Yes	No
Alzheimer's Disease	Yes	No	Diabetes	Yes	No	Hepatitis A	Yes	No	Recent Weight Loss	Yes	No
Anaphylaxis	Yes	No	Drug Addiction	Yes	No	Hepatitis B or C	Yes	No	Renal Dialysis	Yes	No
Anemia	Yes	No	Easily Winded	Yes	No	Herpes	Yes	No	Rheumatic Fever	Yes	No
Angina	Yes	No	Emphysema	Yes	No	High Blood Pressure	Yes	No	Rheumatism	Yes	No
Arthritis/Gout	Yes	No	Epilepsy or Seizures	Yes	No	High Cholesterol	Yes	No	Scarlet Fever	Yes	No
Artificial Heart Valve	Yes	No	Excessive Bleeding	Yes	No	Hives or Rash	Yes	No	Shingles	Yes	No
Artificial Joint	Yes	No	Excessive Thirst	Yes	No	Hypoglycemia	Yes	No	Sickle Cell Disease	Yes	No
Asthma	Yes	No	Fainting Spells/Dizziness	Yes	No	Irregular Heartbeat	Yes	No	Sinus Trouble	Yes	No
Blood Disease	Yes	No	Frequent Cough	Yes	No	Kidney Problems	Yes	No	Spina Bifida	Yes	No
Blood Transfusion	Yes	No	Frequent Diarrhea	Yes	No	Leukemia	Yes	No	Stomach/Intestinal Disease	Yes	No
Breathing Problems	Yes	No	Frequent Headaches	Yes	No	Liver Disease	Yes	No	Stroke	Yes	No
Bruise Easily	Yes	No	Genital Herpes	Yes	No	Low Blood Pressure	Yes	No	Swelling of Limbs	Yes	No
Cancer	Yes	No	Glaucoma	Yes	No	Lung Disease	Yes	No	Thyroid Disease	Yes	No
Chemotherapy	Yes	No	Hay Fever	Yes	No	Mitral Valve Prolapse	Yes	No	Tonsillitis	Yes	No
Chest Pains	Yes	No	Heart Attack/Failure	Yes	No	Osteoporosis	Yes	No	Tuberculosis	Yes	No
Cold Sores/Fever Blisters	Yes	No	Heart Murmur	Yes	No	Pain in Jaw Joints	Yes	No	Tumors or Growths	Yes	No
Congenital Heart Disorder	Yes	No	Heart Pacemaker	Yes	No	Parathyroid Disease	Yes	No	Ulcers	Yes	No
Convulsions	Yes	No	Heart Trouble/Disease	Yes	No	Psychiatric Care	Yes	No	Venereal Disease	Yes	No
Yellow Jaundice	Yes	No									

Have you ever had any serious illness not listed above? Yes No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date:_____