Southern Arizona Periodontics, P.L.C.

Periodontics and Dental Implants

PATIENT REGISTRATION

TODAY'S DATE _____ EXAMINING DENTIST ☐ SUSAN B. SHARP, D.D.S ☐

☐ MR. ☐ MRS. ☐ DR. ☐ MS. PATIENT NAME _____ NICKNAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

BIRTH DATE _____ PATIENT'S SS# _____ GENDER _____

EMAIL ADDRESS _____

IS ANOTHER MEMBER OF YOUR FAMILY, OR RELATIVE A PATIENT AT OUR OFFICE? _____

WHO REFERRED YOU TO US? _____

PERSON TO CONTACT FOR EMERGENCY _____ RELATIONSHIP _____ PHONE NUMBER _____

CLOSEST RELATIVE NOT LIVING WITH YOU _____

ADDRESS _____ PHONE NUMBER _____

WHO IS YOUR GENERAL DENTIST?

PRIMARY DENTAL INSURANCE

EMPLOYER _____

INSURANCE COMPANY NAME _____

POLICY HOLDER'S NAME _____

POLICY HOLDER'S ID (SSN or ID#) _____

BIRTH DATE _____

OCCUPATION _____

RELATIONSHIP TO POLICY HOLDER _____

ARE YOU A FULL TIME STUDENT? _____ WHERE _____

SECONDARY DENTAL INSURANCE

EMPLOYER _____

INSURANCE COMPANY _____

POLICY HOLDER'S NAME _____

POLICY HOLDER'S ID (SSN or ID#) _____

BIRTH DATE _____

OCCUPATION _____

RELATIONSHIP TO POLICY HOLDER _____

ARE YOU A FULL TIME STUDENT? _____ WHERE _____

This form MUST be completed prior to your first appointment.

rev 10/14

Southern Arizona Periodontics, P.L.C.

Susan B. Sharp, D.D.S.

MEDICAL HISTORY

PATIENT'S NAME		EXAMINING DOCTOR
Name of Medical Doctor	Phone Number	Date of Last Medical Exam

Are you allergic to or have experienced any ill effects from:

☐ PENICILLIN	☐ CODEINE	☐ ASPIRIN	☐ NITROUS OXIDE
☐ TETRACYCLINE	☐ PERCOCET	☐ IBUPROFEN	☐ LATEX
☐ ERYTHROMYCIN	☐ DEMEROL	☐ XYLOCAINE	☐ OTHER
☐ OTHER ANTIBIOTICS	☐ VALIUM	☐ CARBOCAINE	☐ NO KNOWN ALLERGIES

Have you ever had any of the following:

Y	N		Y	N		Y	N		Y	N	
☐	☐	Heart Disease or Attack	☐	☐	Asthma	☐	☐	Anemia	☐	☐	Epilepsy or Seizures
☐	☐	High Blood Pressure	☐	☐	Diabetes	☐	☐	Tuberculosis	☐	☐	Fainting
☐	☐	Heart Pacemaker	☐	☐	Ulcers	☐	☐	Thyroid Disease	☐	☐	Nervous Problems
☐	☐	Angina Pectoris	☐	☐	Anorexia / Bulimia	☐	☐	Kidney Disease	☐	☐	Mental Illness
☐	☐	Stroke	☐	☐	Alcoholism	☐	☐	Hepatitis A (infectious)	☐	☐	Psychiatric Treatment
☐	☐	Mitral Valve Prolapse	☐	☐	Drug Addiction	☐	☐	Hepatitis B (serum)	☐	☐	Convulsions
☐	☐	Heart Murmur	☐	☐	Cancer	☐	☐	Hepatitis C	☐	☐	Artificial Joints (hip, knee)
☐	☐	Circulatory Problems	☐	☐	Chemo - Radiation	☐	☐	Rheumatic Fever	☐	☐	PREMED NECESSARY
☐	☐	Emphysema	☐	☐	Malignancies - Cancer	☐	☐	Venereal Disease	☐	☐	Phen-fen/Redux Usage
☐	☐	Respiratory Problems	☐	☐	Abnormal Bleeding	☐	☐	HIV Positive	Other Health Concerns:		
☐	☐	Sinus Problems	☐	☐	Hemophilia	☐	☐	AIDS			

What medications or drugs are you taking at this time?

Are you a smoker? ☐ NO ☐ YES: *How Many?* _____

Females: Are you pregnant or trying to become pregnant? ☐ NO ☐ YES: *How Many Months?* _____

Medical history reviewed by Dr. _____ *Date* _____

DENTAL HISTORY

What is your immediate problem?

Have you ever had periodontal treatment? ***When:***

What is your maintenance cleaning schedule? ***When was your last cleaning?***

CONSENT

SOUTHERN ARIZONA PERIODONTICS, P.L.C. recognizes that every patient has the Right of Privacy concerning their personal dental health information. I confirm that I have read a copy of the Notice of Privacy Practices and understand my rights.

X Signed: ***Date***

AUTHORIZATION TO PAY BENEFITS TO DENTISTS: I hereby authorize payment directly to the Dentist of the Sui Dental Benefits, if any, otherwise payable to me for the services as described but not to exceed the reasonable and customary for those services. I understand I am financially responsible for charges not covered by this authorization. In th default I agree to pay together with such collection costs and responsible attorney's fees as may be required.

X Signed: ***Date***

The undersigned hereby authorizes the Doctor to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize the Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with (Name of Patient) _____ and further authorize and consent that Doctor choose and employ such assistance as deems fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered. In the event of default I (We) promise topay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

X Patient: ***Date*** ***Witness***

X Parent or Responsible Party ***Relationship to Patient***

UPDATES

Date ☐ No Changes ☐ Changes: _____ Patient Signature: _____

Date ☐ No Changes ☐ Changes: _____ Patient Signature: _____

Date ☐ No Changes ☐ Changes: _____ Patient Signature: _____

Southern Arizona Periodontics, P.L.C.

PERIODONTAL AND DENTAL IMPLANTES

5225 E. Knight Drive, Suite 401~ Tucson, Arizona 85712 403 W. Cool Drive, Suite 101 ~ Tucson, Arizona 85704

- **Teléfono: (520) 322-9300 Numero Sin Consto: (877) 437-139**

INSTUCCIONES ANTES DE CIRUGIA:

1. Usar camisa o blusa de manga corta.
2. Después de su cita alguien deberá conducirlo a su casa si se le ha dado algún sedante.
3. Si le van a dar sedante y su cita está programada por la mañana, por favor no se desayune ni tome nada. Si su cita esta por la tarde, por favor desayune pero no haga su comida. ¡NO CAFÉ! ¡NO TE!
4. En caso individuales requiere premediación cuando hay historial médico de condición cardiaca y hay remplazo quiricos.
5. Necesitará anticipar su cita para su cuidado posquirúrgico.
6. Nuestro personal se pondrá en contacto con usted aproximadamente una semana por adelantado para confirmar su cita y arreglos financieros. Si tiene alguna pregunta respecto a lo anterior favor de ponerse en contacto con nuestra oficina.
7. Necesitas venir acompañada que te pueda esperar en la sala pro precaución.

INSTRUCCIONES DESPUES DE CIRUGIA PERIDONTAL:

1. Enjuagándose l boca vigorosamente interviene con la coagulación de la sangre, es muy importante que no se enjuague la boca el día de la operación.
2. Espere incomodidad moderada, posiblemente dure por varios días. Tome su medicina recetada mientras la necesite. No fume o use paja el mismo día de la cirugía.
3. Si un antibiótico se le ha recetado, tome se las pastillas o capsulas dirigidas. Si le resulta reacción a la medicina como (ronchas, sarpullido, picazón, etc.) en este caso discontinúe antibiótico inmediatamente y llame a la oficina lo más pronto hinchazón.
4. Aplíquese hielo por 15 minutos y quíteselo por otros 15 minutos. Repita este proceso hasta su hora de dormir. Haga este proceso solamente el día de su cirugía. Hinchazón moderado a severo podría ocurrir durante de 3 a 5 días. Si sigue con hinchazón después del segundo día, aplíquese una toalla tibia al área para ayudar reducir la hinchazón.
5. Empezando el segundo día, enjuagase la boca suavemente con agua tibia y sal. (una cucharadita de sal a un vaso de agua)
6. Consuma comidas blanda con mucha proteína, (huevos, leche, pollo, queso, pescado) hasta su siguiente vista postoperatorio.
7. Absolutamente No se cepille el área operada hasta su siguiente vista postoperatorio. Está bien cepillar las otras partes de la boca. Le daremos instrucciones apropiadas en el cuidado de su boca.
8. Si le han dado una venda quirúrgico, NO se la torque o moleste.
9. Si la han dado una solución azul para limpiarse los dientes, moje un algodón con la solución y limpieza los dientes operados tres veces por día, por una semana.
10. Si usaron suturas de disolver, posiblemente comenzaran a disolverse o aflojarse solos. Esto ocurre ente 4 a 5 días postoperatorio. Usted con cuidado, puede quitarse las si desea, pero no es necesario.
11. COMPLICACIONES: Sangrando severamente, temperatura elevada, o excesivo hinchazón caliente, ocurriendo pocos días después de la operación, son complicaciones. Llame a la oficina inmediatamente. Si usted está sangrando, puede controlar la sangre con bolsita de te o gasa en la área sangrando, aplicando presión continuamente por 30 minutos.
12. Regrese a la oficina para remover su vence quirúrgico y suturas, y para examen postoperatorio como está dirigido.
13. No es raro sintir incomodidad aumentado en el tercer o cuarto día después de cirugía.
14. Para problemas después de las horas de oficina, llame a nuestra casa. Siempre estamos disponibles.

Dr. Sharp…… (520) 869-2583

O Línea de Emergencia …… (520) 322-9300 opción 2

Southern Arizona Periodontics, P.L.C.

Periodontics and Dental Implants

5225 E. Knight Drive Suite 401
Tucson, Arizona 85712
(520) 322- 9300

403 W. Cool Drive, Suite 101
Tucson, Arizona 85704
(520) 322-9300

We recommend a soft diet after your periodontal surgery. We hope these sample menus will be a guide to good nutrition during your recovery. In addition, we recommend keeping your intake of refined sugar to a minimum and using fructose as a sweetener. * Also, we encourage you to take 500mg of Vitamin C three times per day and 25mg of Zinc one time per day during recovery.

SAMPLE MENUS

Breakfast
Hot Cereal
Banana
2% milk

Lunch
Gazpacho
Scrambled eggs

Dinner
Cream of mushroom soup
Baked Potato
Stewed tomatoes

Snacks
Applesauce
Yogurt

Breakfast
Unsweetened Juice
Poached eggs
Soft whole wheat bread

Lunch
Chicken noodle soup
Macaroni and cheese

Dinner
Vegetable soup
Pasta
Stewed fruit

Snacks
Diet Jell-o
Chopped liver

Breakfast
Oatmeal with raisins

2% milk

Lunch
Tomato rice soup
Cheese omelet

Dinner
Cream of potato soup
Tuna fish
Yellow Squash

Snacks
Custard
Stewed fruit

Breakfast
Tomato Juice
Soft boiled eggs
Soft whole wheat bread

Lunch
Beef noodle soup
Cottage cheese with Soft fruit

Dinner
Tomato soup
Stewed chicken
Brown rice

Snacks
Instant noodle soup

Breakfast
Cream of Wheat
Grated apple
2% milk

Lunch
Scrambled eggs
Grits

Dinner
Lentil soup
Stuffed baked potato
Chopped spinach

Snacks
Cottage cheese and soft fruit

HELPFUL UTENSILS

Blenders
Food Processor
Food grinders
Pressure cookers

BEVERAGES

Herbal teas
Powdered Vegetable Broth
Coffee
Vegetable juices
Unsweetened Juices
Diet sodas

OTHER HELPFUL HINTS

* Fructose, which can be purchased in any grocery store, does not promote tooth decay. Substitute for refined sugar in recipes calling for sugar

** Teeth may be sensitive to cold foods

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW PRIVATE HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU MAY ACCESS THIS INFORMATION

Our Healthcare Practice takes patient privacy matters seriously. We work hard to meet and exceed all existing rules and regulations and will work to keep you informed regarding our office policies and your personal rights regarding privacy.

We are required by federal and state law to maintain the privacy of your health information. We are also required to give you this NOTICE about our privacy practices, our duties, and your rights concerning your personal health information. We must follow the privacy practices described in this Notice while it is in effect. This Notice takes effect on April 14, 2003, and will remain in effect until we replace it, at which time we will issue a new Notice to Patients indicating a new activation date. You may request a copy of our Notice at any time, and may request additional copies, as needed by contacting our office.

How We Disclose Health Information:

Specialist Referrals:
We use and disclose health information about you for treatment within our practice, for general healthcare operations, and payment collection. That means your information is available to our immediate staff, and to other practitioners who we may refer you to for additional treatment. This includes, but is not limited to, other healthcare specialists such as surgeons, laboratories and the like. We will exercise our judgment in only distributing the minimum necessary information needed when sending health information to any outside Associates.

General Business Operations:
Your information may be reviewed in the course of general healthcare operations for activities such as conducting quality reviews, assessing practitioner performance, evaluation of business costs, conducting training programs, licensing, accreditation, and certain certification activities, and other business related evaluations to help us in improving our delivery of healthcare to our patients.

Payment and Collection:
Your health information will be sent to third party payers for insurance collection and, when applicable, to collection agencies for assistance to us receiving payment for services rendered. Additionally information may be used from time to time as necessary to secure payment for services. We will use our professional judgment and experience with common practice to make decisions on what information to disclose to secure payment.

Family, Friends, Personal Representatives and Others:
We may disclose your health information to a family member, friend, or other persons to the extent necessary to help with your healthcare or with payment for your healthcare. You may however request that we not disclose to anyone other than yourself, of which we will abide. An example where we might disclose to a family member or friend might be when someone drives you to the practice and we are reporting on progress and time remaining before completion, or where a family member desires to pick up a prescription or x-rays on your behalf. We will use our professional judgment and experience with common practice when disclosing your health information that it is directly relevant to the person's involvement in your healthcare. We may disclose health information to others who may be involved in your health care and are trying to ascertain your general condition, your current location, or learn of your death.

Marketing Health-Related Services:
We will not use your health information for marketing communications without your written authorization. Under federal privacy rules we may send you update information about our practice or healthcare system, send you information regarding programs and products we offer to further enhance your care and treatment, send reminder notices for appointments, and offer small nominal gifts from time to time, such as tooth brushes, which is not considered marketing. We will never provide your name to an outside organization for marketing.

Our Business Associates:
We require all of our Business Associates to sign a contract specifying they too are strictly following patient privacy rules and regulations. We will act swiftly and decisively if we find any violated provisions of their contract.

When the Law Requires Us to Disclose:
We may disclose your health information to government agencies or others, as required by law. Examples of this include, but are not limited to, law enforcement, required state agency reporting, or coroners seeking to confirm identity. Additionally we disclose to military authorities for purposes such as national security.

Abuse and Neglect:
We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence, or are the victim of possible other crimes. We disclose to the extent necessary to avert further harm to you or others.

PATIENT RIGHTS

Access to Records:
You have a right to look at copies of your health information, with limited exceptions. You may request photocopies and copies of x-rays. We will use the format you request, unless we are unable to practically do so. You must make your request to access for health information in writing to our practice. We can provide you with a form to do this, or you may do it by writing a letter specifying exactly what you want to view. If we provide photocopies we will charge you a set amount for each page copied. If you wish to receive x-ray duplicates we will charge you a set fee per film copied. Check with the office for the current fee schedule. If you request an alternate format we will charge you per the expenses we incur to satisfy your request. You may prefer to ask for a summary rather than receive all of the pages in your file. We can prepare a summary depending on what you are seeking to obtain. The fee for summation will vary depending on time to compile. The hourly rate for summation is also on our current fee schedule.

We have up to 30 days (and sometimes longer) to respond, depending on what is required to meet your request. Specifics will be provided upon request.

List of Disclosures:
You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations and a few other activities as specified by law, for the last six years, but not before April 14, 2003. If you request this list more than once in a 12 month period we will charge you a reasonable cost based fee for responding to the additional requests. Fees will be disclosed prior to action being taken.

Restrictions:
You have the right to place additional restrictions on our use or disclosure of your health information. We are not required to agree to these restrictions, however, if we do agree, we will abide by our agreement, except in certain emergency situations.

Communications to You:
You may request we communicate with you about your health information by alternative means or to alternative locations, when you make the request in writing. You must specify the alternative means or locations and provide satisfactory explanation how payments will be made under the alternative means or location.

Amendment of Your Records:
You have the right to request that we amend your health information when requested in writing. We may deny your request however, we will note in your records your request to amend and reason. We cannot delete anything from the formal record but we can add addendums to the record that may be able to meet your amendment request.

Electronic Notice of this Information:
If you received this information electronically (via email), you are entitled to receive this in written hard copy form.

Patient signature _____ Date _____