ROBERT S. GUIER, D.D.S. **PERIODONTICS**

"Reshaping a Quality of Life Through a Commitment to Excellence."

Confidential Patient Information

Date:

Patient's Name: **Home Phone:** **Cell:**
Address: **City:** **State:** **Zip:**
Date of Birth: **SS#:** **Work Phone #:**
Marital Status: (please circle): Married Divorced Single Widow
Email
Patient's Employer **Address:**

Person responsible for account (only if patient is a minor):

Whom may we thank for referring you to our office?

Dental Insurance Carrier:
Address:
Insurance is through what place of employment?:
Group # **Member #** **Phone #**
Insured's Name: **Insured's Date of Birth:**

Dental Health: (please check one) [ ] Excellent [ ] Good [ ] Fair [ ] Poor

What priority do you give your teeth (10 being the highest)?* 1 2 3 4 5 6 7 8 9 10
***(How important are your teeth to you?)**

Medical Health: (please check one) [ ] Excellent [ ] Good [ ] Fair [ ] Poor
Physician's Name: **Phone #**

Are you under a doctor's care now? **If yes, for what reason?**

Please list <u>all</u> medications you are taking:

Please check if you take [ ] *aspirin or* [ ] *blood thinners* on a regular basis

Are you taking Viagra, Vioxx, or Celebrex? **If yes, please circle which one.**

Have you ever receive a blood transfusion? [ ] No [ ] Yes Approximate Date:

Are you or do you suspect you might be pregnant? [ ] No [ ] Yes If yes, how long?

Are you subject to prolonged [ ] *bleeding* or [ ] *fainting spells*?

Are you allergic to: [ ] *Penicillin* [ ] *Codeine* [ ] *Local Anesthetics*

List any other medication allergies not named above

2001 E.70th St. Suite 505 Shreveport, LA 71105 Telephone: (318) 798-1201 Facsimile: (318) 798-1202

ROBERT S. GUIER, D.D.S. **PERIODONTICS**

"Reshaping a Quality of Life Through a Commitment to Excellence."

Please circle if you have or have had any of the following:

Heart Trouble	Fainting or Dizziness	Hepatitis B (serum)
Heart Murmur	High Blood Pressure	Hepatitis A (infectious)
Artificial Heart Valve	Low Blood Pressure	Cancer:_____
Mitral Valve Prolapse	Artificial Joints, Hips, Knees	Thyroid Disease
Heart Pacemaker	Allergies	Chemotherapy/Radiation
Diabetes	Asthma	Arthritis/Gout
Anemia	Severe Sinus Problems	Glaucoma
HIV Positive	Tuberculosis	Lung Disease
Emphysema	Liver Disease	Stroke
Epilepsy or Seizures	Alzheimer's Disease	Hypoglycemia
Hemophilia	Prostate Troubles	Psychiatric Care
Chest Pain	Frequent Cough	Swelling of Feet/Ankles

Have you had any other serious illness not listed above? [ ] Yes [ ] No
If yes, please describe in detail: _____

_____

Dental History

[ ] Yes [ ] No Do you bleed excessively after tooth extraction?
[ ] Yes [ ] No Have you had an undesirable reaction to local or general anesthetic?
[ ] Yes [ ] No Have you had excessive swelling or pain after oral surgery?
[ ] Yes [ ] No Are you dissatisfied with the appearance of your teeth?
[ ] Yes [ ] No Do you clench or grind your teeth?
[ ] Yes [ ] No Does food pack between your teeth?
[ ] Yes [ ] No Are your teeth sensitive to cold or sweets?
[ ] Yes [ ] No Does your jaw pop or click when you chew?
[ ] Yes [ ] No Do you have a bad taste in your mouth?
[ ] Yes [ ] No Have you ever received treatment for periodontal disease?
[ ] Yes [ ] No Has a dentist ever grounded your teeth to correct your bite?
[ ] Yes [ ] No Are you willing to become actively involved in the treatment of your periodontal disease?

FEES

I understand and agree that I am responsible for all fees incurred by my immediate family and myself and these fees are due and payable according to the financial policies of this practice. I authorize Dr. Robert S. Guier to release any information including the diagnosis and records of any treatment and exam rendered to third party payers and/or heath practitioner. I understand that my dental insurance is a contract between the carrier and me and not between Dr. Guier and the carrier. I also understand that Dr. Guier's office will file my primary dental insurance as well as any secondary. I authorize and request my insurance company to pay directly to Dr. Guier's insurance benefits otherwise payable to me.

_____ _____
Signature of patient or guardian Date

2001 E.70th St. Suite 505 Shreveport, LA 71105 Telephone: (318) 798-1201 Facsimile: (318) 798-1202

"Reshaping a Quality of Life Through a Commitment to Excellence."

Notice to Patients who have taken
Bisphosphonate Medication

Introduction

Bisphosphonates are a class of drugs that inhibit bone thinning. They are commonly prescribed in the treatment of:

- **BONE CANCER**
- **BONE CANCER DUE TO BREAST CANCER**
- **PROSTATE CANCER**
- **ANY OTHER CANCER THAT MAY HAVE SPREAD TO YOU BONES**
- **OSTEOPOROSIS**
- **OSTEOPENIA**
- **POST-MENOPAUSAL BONE LOSS**

These drugs are given **intravenously** in cancer treatment and have brand names such as but not limited to:

- **BONEFOS**
- **AREDIA**
- **SKELIDE**
- **ZOMETA**

WHEN WAS YOUR LAST INTRAVENOUS INJECTION _____

These drugs are taken in **pill form** for osteoporosis treatment and have brand names such as but not limited to:

- **FOSAMAX**
- **DIDRONEL**
- **ACTONEL**
- **BONVIA**

WHEN DID YOU LAST TAKE THIS MEDICATION _____

These drugs stay in the body and may cause side effects many years after they are taken.

Signature

I certify that I speak, read, and write English. I further certify that I have read and fully understand the above notice and have had all of my questions answered.

Does this apply to you? q **Yes** q **No**

_____	_____	_____
Patient's (or legal Guardian's) Signature	Date	Witness Signature

2001 E.70th St. Suite 505 Shreveport, LA 71105 Telephone: (318) 798-1201 Facsimile: (318) 798-1202

"Reshaping a Quality of Life Through a Commitment to Excellence."

DIABETIC PATIENTS

Patients with diabetes need to understand that they have numerous problems associated with this disorder. Most of these problems are because of the vascular complications associated with diabetes. This may cause the patient to be more susceptible to bone loss, infection and possibly implant failure.

You are being informed that these complications can occur and that you must do four important things to help this situation.

1. Regular checkups and maintain a balanced, controlled, normal sugar level. This can only be obtained with full compliance with your physician's supervision.
2. Maintain excellent oral hygiene as discussed with our office using the Sonicare with peridex three times a day
3. Go to your dentist at least three times yearly for cleanings, etc…
4. Return to Dr. Guier annually for periodic exams.

Following these instructions does not guarantee success of your implants, but certainly increases your chances of success. Dr. Guier is not liable for these complications if they do occur due to non-control or non-compliance with your diabetes.

I,_____, do understand the above statements and agree to follow these instructions.

Signature

I certify that I speak, read, and write English. I further certify that I have read and fully understand the above notice and have had all of my questions answered.

Does this apply to you? **q Yes** **q No**

_____	_____	_____
Patient's (or legal Guardian's) Signature	Date	Witness Signature

2001 E.70th St. Suite 505 Shreveport, LA 71105 Telephone: (318) 798-1201 Facsimile: (318) 798-1202

"Reshaping a Quality of Life Through a Commitment to Excellence."

SMOKING and SMOKELESS TOBACCO AS IT RELATES TO DENTAL IMPLANTS

IMPLANT PATIENTS WHO SMOKE DO NOT HEAL AS WELL AS NON-SMOKERS

Newly sutured tissue heals by clotting. When a patient inhales, they form a vacuum in the mouth and often times dislodge the newly formed clot. Nicotine then penetrates that clot and can cause necrosis (death in some or all cells in an organ or tissue) of the tissue.

To decrease post-op complications, our patients are instructed that they must not smoke and/or use smokeless tobacco products after their implant surgery. If the patient at any time resumes smoking and/or uses smokeless tobacco products after the surgery numerous complications could occur, such as, but not limited to: dry sockets, bone loss around the implants, infection or failure of the dental implant. Dr. Guier is not liable for any complications that occur in patients that choose to smoke and/or uses smokeless tobacco products.

I,_____, understand the above statements and agree to stop smoking and/or using smokeless tobacco products for **three days** (minimum) prior to my surgical procedure and for an **additional one month** following my surgical procedure. I also understand that I am responsible for any complications resulting from the effects of smoking and/or the use of smokeless tobacco products, such as infection or implant loss, if I do not follow the above instructions.

Signature

I certify that I speak, read, and write English. I further certify that I have read and fully understand the above notice and have had all of my questions answered.

Does this apply to you? q **Yes** q **No**

_____ _____ _____

Patient's (or legal Guardian's) Signature Date Witness Signature

2001 E.70th St. Suite 505 Shreveport, LA 71105 Telephone: (318) 798-1201 Facsimile: (318) 798-1202

"Reshaping a Quality of Life Through a Commitment to Excellence."

SMOKING and SMOKELESS TOBACCO AS IT RELATES TO GUM GRAFTING

GRAFTING PATIENTS WHO SMOKE DO NOT HEAL AS WELL AS NON-SMOKERS

Newly sutured tissue heals by clotting. When a patient inhales, they form a vacuum in the mouth and often times dislodge the newly formed clot. Nicotine then penetrates that clot and can cause necrosis (death in some or all cells in an organ or tissue) of the tissue.

To decrease post-op complications, our patients are instructed that they must not smoke and/or use smokeless tobacco products after their implant surgery. If the patient at any time resumes smoking and/or uses smokeless tobacco products after the surgery numerous complications could occur, such as, but not limited to: infection or failure of the gum graft. Dr. Guier is not liable for any complications that occur in patients that choose to smoke and/or uses smokeless tobacco products.

I,_____, understand the above statements and agree to stop smoking and/or using smokeless tobacco products for **three days** (minimum) prior to my surgical procedure and for an **additional one month** following my surgical procedure. I also understand that I am responsible for any complications resulting from the effects of smoking and/or the use of smokeless tobacco products, such as infection or gum graft failure, if I do not follow the above instructions.

Signature

I certify that I speak, read, and write English. I further certify that I have read and fully understand the above notice and have had all of my questions answered.

Does this apply to you? q **Yes** q **No**

_____	_____	_____
Patient's (or legal Guardian's) Signature	Date	Witness Signature

2001 E.70th St. Suite 505 Shreveport, LA 71105 Telephone: (318) 798-1201 Facsimile: (318) 798-1202

ROBERT S. GUIER, D.D.S. **PERIODONTICS**

"Reshaping a Quality of Life Through a Commitment to Excellence."

HIPPA CONSENT FORM

Please tell us with whom we are allowed to discuss and/or disclose your personal health information.

Name:_____ Relationship:_____

Name: _____Relationship:_____

Name: _____Relationship:_____

My signature below authorizes the release of medical information to any specialists I may be referred to and process insurance claims/applications, prescriptions and lab work.

I understand that under the HIPPA act, I have certain rights to privacy regarding my protected health information I understand this information can be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read, and understand your Notice of Privacy Practice containing a more complete description of the uses and disclosures of my health information. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations.

I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide such restrictions.

_____
Patient/Responsible Party Name

_____ _____
Patient/ Responsible Party Signature Date

_____ _____
INS/ISS Employee Signature Date

2001 E.70th St. Suite 505 Shreveport, LA 71105 Telephone: (318) 798-1201 Facsimile: (318) 798-1202