Galleria Periodontics & Implants
Practice Limited to Periodontics & Dental Implants
5858 Westheimer, Suite 820
Houston, Texas 77057
713-784-6065
www.galleriaperio.com

Patient Demographics

Last _____ First _____ Middle _____

Preferred _____ Title _____ ❑ Male ❑ Female ❑ Single ❑ Married ❑ Child ❑ Other

Birth Date _____ S.S.# _____ Drivers License # _____

Address _____

Address _____

City _____ State _____ Zip _____

E-mail _____ Home Phone _____

Work Phone _____ Ext. _____ Best time to call _____

Fax _____ Pager/Cell _____ Other _____

Employer Information

Employer Name _____ Phone _____

Address _____ Occupation _____

Address _____

City _____ State _____ Zip _____

Insurance Information

Primary

Name of Insured _____ Is insured a patient? ❑ Yes ❑ No

Birth Date _____ ID# or SSN _____ Group# _____

Insured's Employers Name _____ Phone# _____

Patient's relationship to insured ❑ Self ❑ Spouse ❑ Child Other _____

Insurance Plan Name _____

Address _____ City _____ State _____ Zip _____

Phone # _____

Whom may we thank for referring you to our practice? _____

Phone# _____

In case of emergency, please contact Name _____

Home Phone _____ Work Phone _____

Medical History

Do you now or have you ever had any of the following? **Please answer yes or no to ALL questions.**
* If yes to any of the starred conditions, please call prior to your appointment, premedication may be required.

	Yes	No
Anemia	❑	❑
Angina/Chest Pain	❑	❑
Artificial Heart Valve*	❑	❑
Aspirin Therapy (Taken Daily)	❑	❑
Asthma	❑	❑
Alzheimer's Disease	❑	❑
Arthritis/Gout	❑	❑
Artificial Joint*	❑	❑
Bleeding Tendency	❑	❑
Blood Disease	❑	❑
Breathing Problem	❑	❑
Bruise Easily	❑	❑
Cancer; Type _____	❑	❑
Chemotherapy	❑	❑
Cold Sores	❑	❑
Congenital Heart Disorder	❑	❑
Convulsions	❑	❑
Cortisone Medication	❑	❑
Coumadin	❑	❑
Diabetes/Family History of Diabetes	❑	❑
Drug Addiction/Alcoholism	❑	❑
Emphysema	❑	❑
Fainting Tendency	❑	❑
Fever Blisters	❑	❑
Frequent Cough	❑	❑
Frequent Diarrhea	❑	❑
Glaucoma	❑	❑
Grind Teeth	❑	❑
Heart Attack/Failure	❑	❑
Heart Murmur*	❑	❑
Heart Pacemaker*	❑	❑
Heart Problems	❑	❑
Heart Surgery	❑	❑
Hemophilia	❑	❑
Hepatitis Circle one A B C	❑	❑
Herpes	❑	❑
HIV/AIDS	❑	❑
High Blood Pressure	❑	❑
High Cholesterol	❑	❑
Hives	❑	❑
Hypoglycemia	❑	❑
Kidney Problems	❑	❑
Leukemia	❑	❑
Liver Problems	❑	❑
Lung Disease	❑	❑
Mitral Valve Prolapse*	❑	❑
Nervousness	❑	❑
Pain in Jaw Joints	❑	❑
Plavix	❑	❑
Psychiatric Care	❑	❑
Recent Blood Transfusion	❑	❑
Renal Dialysis	❑	❑
Rheumatic/Scarlet Fever*	❑	❑
Rheumatoid Arthritis	❑	❑
Seizures or Epilepsy	❑	❑
Shortness of breath when lying down	❑	❑
Sickle Cell Anemia	❑	❑
Sinus Trouble	❑	❑
Stomach/Intestinal Disease	❑	❑
Stroke	❑	❑
Thyroid Disease	❑	❑
Tuberculosis	❑	❑
Tumors or Growths	❑	❑
Ulcers	❑	❑
Women (Taking Oral Contraceptives?)	❑	❑
X-Ray Treatments (Radiation)	❑	❑

Have you ever had any other serious illness not checked above? Discuss _____

	Yes	No
Is your past and present health good?	❑	❑
Are you pregnant/nursing?	❑	❑
Are you allergic to any medications?	❑	❑

❑ Aspirin ❑ Penicillin ❑ Codeine ❑ Acrylic ❑ Metal
❑ Latex Rubber ❑ Dental anesthesia, gas or novocaine
❑ Other_____

	Yes	No
Do you ❑ smoke ❑ chew ❑ dip	❑	❑
Have you ever had to premedicate with antibiotics prior to Dental Care?	❑	❑

Dental- Periodontal History

	Yes	No
Have you ever been treated for periodontal problems before? If so, when? _____	❑	❑
Unpleasant taste and/or odor in your mouth?	❑	❑
Is there any family history of periodontal problems?	❑	❑
Do your gums bleed?	❑	❑
Do you have pain in your gums?	❑	❑
Do you gag easily?	❑	❑
Do your gums feel swollen?	❑	❑

	Yes	No
When was your last Dental Cleaning? _____		
Do you have pain/sensitivity in your teeth?	❑	❑

Brush _____ times a day with:
❑ Soft ❑ Medium ❑ Hard brush.
Is your toothbrush hand held or electric? _____
Floss _____ times a day with:
❑ Unwaxed ❑ Waxed ❑ by Hand ❑ Holder
Brush & floss: ❑ Morning ❑ Noon ❑ After Dinner ❑ Bedtime

Please list any medications you are taking and their dosages: _____

_____

Physician's name/phone # _____ Date of last physical examination _____

Is there any other medical information that we should know that would be pertinent to our treating you? _____

_____

To the best of my knowledge, all of the preceeding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor at the next appointment without fail. I, the undersigned (Patient or Legal Guardian), authorize Periodontal Treatment to be rendered and assume financial responsibility.

Signature _____

Date _____

Wesam Salha, D.D.S., M.S.D.

PATIENT CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

TO THE PATIENT - PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices. Those changes may apply to any of your protected health information that we maintain.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to our office. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

Consent: I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

Signature:_____

Date:_____

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Representative's Name:_____

Relationship to Patient:_____

Revocation of Consent: I revoke my Consent for your use and disclosure of my protected health information. I understand that revocation of my Consent before you received this written Notice of Revocation does not apply. **I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.**

Print Name: _____

Signature:_____

Date:_____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT FORM
