Prostho Dental
Implant and Aesthetic Dentistry

15555 Creekbend Dr., Suite 100
Sugar Land, TX 77478
P: 281-207-0782 F: 281-207-0783
www.prosthodental.com

Patient Information Form

First Name:_____ **Middle Initial:**_____ **Last Name:**_____

Date of Birth:_____ **Age:**_____

Address:_____

City:_____ **State:**_____ **Zip Code:**_____

How did you hear about us?_____

Cell Phone:_____

Home Phone:_____

Work Phone:_____

Email Address:_____ **Driver's License No.:**_____ **SSN:**_____

Name of Employer:_____ **Occupation:**_____

Employer's Address:_____ **City:**_____ **State:**_____ **Zip Code:**_____

Emergency Contact:_____ **Emergency Phone No.:**_____

Sex: Male__ Female__ Unspecified__ **Marital Status:** Married__ Single__ Divorced__ Separated__ Widowed__

If married, name of spouse:_____

Preferred Method of Payment: Financing ☐ Credit Card ☐ Cash ☐ Insurance ☐ Family Member ☐
401K ☐ Life Insurance Policy ☐ Home Equity ☐

Dental Habits

How often do you brush your teeth?	__Weekly	__Once a day	__2+ times a day
How often do you floss your teeth?	__Rarely/Never	__Daily	__Other
How often do you visit a dentist?	__1+ times a year	__Every few years	__Rarely/Never

_____ _____
Dentist's Name (if applicable) Last visit (Month/Year)

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HIPAA CONSENT

Consent for Release of Information for Treatment, Payment, and Health Care Operations.

The Health Insurance Portability and Accountability Act (HIPAA) requires that Prostho Dental make available to you a description of how medical information about you may be used or disclosed and how you can get access to this information. This is called the Notice of Privacy Practices and copies are available on the receptionist's desk and waiting room. I acknowledge that a copy of this notice has been made available to me.

_____ Initials

In addition to our use of your health information for treatment, payment, or healthcare operations, you may give us written authorization to use your health information or to disclose it to relevant parties for any purpose. If you give us authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

In addition to the above, I authorize the following:

1. My medical condition and information may be discussed with the following persons:

Name:_____ Relationship_____

Name:_____ Relationship_____

2. Leave a message on my phone voice mail or answering machine? **Yes__ No__**

3. Leave a message with a person who answers my home phone? **Yes__ No__**

4. Receive mail at home from our clinic other than billing statements? **Yes__ No__**

5. Contact me at work and tell them who is calling if asked? **Yes__ No__ N/A__**

6. Leave a voice message on my work phone? **Yes__ No__ N/A__**

I,_____, authorize Prostho Dental to use or disclose my health information to carry out my treatment, obtain payment, and for health care operations.

_____ _____
Signature of Patient (or Patient's Representative) Date

_____
Printed Name of Patient (or Patient's Representative)

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PATIENT HEALTH HISTORY

In order to understand your oral health, we must learn about your overall health history. Your health history and medications may affect your oral health treatment plan. Answering the following questions will assist our doctors in creating an appropriate treatment plan for you that takes into consideration your overall health. Your answers to the following questions remain confidential and protected by all applicable healthcare laws.

When was the last time you had a physical exam?_____

Height:_____ Weight: _____

Are you currently in good health? Yes ☐ No ☐ Other:_____

In the last year, have you had any changes to your overall health? Yes ☐ No ☐

Are you currently being treated by a physician for any health condition? Yes ☐ No ☐
If yes, please list the conditions you are being treated for:_____

During the last 5 years, have you been hospitalized for any reason? Yes ☐ No ☐
If yes, please describe the reason you were hospitalized:_____

Have you ever had, or do you currently have, any of the following conditions? (Please check all applicable conditions):

Diabetes		Rheumatic fever		High Blood Pressure	
Low Blood Sugar		Thyroid		Low Blood Pressure	
Stroke		Kidney Disease		Dialysis	
Convulsions, Seizures, Epilepsy		Arthritis		Prosthetic Joint Replacement	
Contagious Diseases		Sexually Transmitted Diseases		Chest Pain or Angina	
Heart Attack		Irregular Heartbeat		Cardiac Pacemaker	
Open Heart Surgery or Angioplasty		Swollen Ankles		Bronchitis and/or Pneumonia	
Chronic Cough		Asthma		Hay Fever/Sinus Problems	
Tuberculosis		Emphysema		Shortness of breath	
Any Type of Lung Trouble		Blood Disorder such as Anemia		Do you bruise easily?	
Prolonged or Heavy Breathing		Blood Transfusion		Cancer, Tumor, or other growth	
Radiation/Chemotherapy		Depression		Eye Disease/Glaucoma	
Removable Dental Appliances		Do you wear contact lenses?		Pain or clicking of the jaw (TMJ)	
Malignant Hyperthermia		Reaction to Anesthesia		Disability	
Cold Sores		Do you smoke?		Drink alcoholic beverages?	
Mental Health Issues		Physical Impairment		Any other condition?	

MEDICATIONS

Are you currently taking any of the following medication?

- Anticoagulants Yes ☐ No ☐
- Tranquilizers/Sleeping pills Yes ☐ No ☐
- Cortisone Yes ☐ No ☐
- Other medications? (Please list all that apply): _____
  _____

Are you currently taking, or have you ever taken any of the following medications to treat osteoporosis or cancer?

Skelid (Tiludronate) ☐ **Bovina** (Ibandronate) ☐ **Didronel** ☐

Zometa (Zoledronic) ☐ **Actonel** (Risedronate) ☐

Aredia (Pamidronate) ☐ **Fosamax** (Alendronate) ☐

ALLERGIES

Are you allergic to, or have you ever had a reaction to any of the following?

- Local anesthesia Yes ☐ No ☐
- Penicillin or other antibiotics Yes ☐ No ☐
- Sulfa drugs Yes ☐ No ☐
- Barbiturates, sedatives, or sleeping pills Yes ☐ No ☐
- Aspirin Yes ☐ No ☐
- Codeine or other narcotics Yes ☐ No ☐
- Other medication? Please list:_____
  _____

For women: Is there ANY possibility you may be pregnant? Yes ☐ No ☐
Are you nursing? Yes ☐ No ☐
Do you take birth control pills? Yes ☐ No ☐

Are there any other conditions concerning your health of which the Doctor should be aware? Yes ☐ No ☐
If yes, please explain:_____

Primary Care Physician: Name:_____ Phone number:_____
Other medical providers: Name:_____ Phone number:_____
Name:_____ Phone number:_____
Name:_____ Phone number:_____
Pharmacy: Name:_____ Phone number:_____

I hereby certify that I have read and understood the above. I acknowledge that my questions, if any, about the above health history questionnaire have been answered to my satisfaction. I will not hold my surgeon or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient's Signature_____ Date_____

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PATIENT DENTAL CONDITION QUESTIONNAIRE

DENTAL CONDITION QUESTIONNAIRE	YES	NO
Are you experiencing pain in your gums and/or teeth?		
Do you like the appearance of your teeth?		
Do you think that your teeth's appearance affects your confidence?		
Are you limited in the foods you can eat?		
Are you experiencing issues speaking clearly because of dental problems?		
Are you currently wearing partial dentures?		
Are you currently wearing full dentures?		
Do you experience sensitivity to pressure, sweets, hot, or cold?		
Do you grind your teeth?		
Have you ever undergone gum surgery?		
Do your gums bleed or hurt?		
Do you have any loose teeth?		
Have you lost any teeth?		
Have any of your teeth been removed or extracted?		
Have you ever had any of your teeth replaced?		

As part of your initial patient consultation, we will take a 3D CT scan to help our doctors make a diagnosis of your oral health and create a treatment plan for you. The scan is an important diagnostic tool because it allows our doctors to view accurate imaging of your teeth and bone. During your consultation, our team will educate you about your oral health, possible treatment plans available to you, costs, and financing. Our goal is to assist you in making an informed decision about your oral health.

I authorize Prostho Dental to take a diagnostic 3D CT scan of me and I understand that the imaging is for internal use only.

_____
Patient Name

_____ _____
Patient Signature Date

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COVID-19 Patient Screening Questionnaire

PATIENT COVID-19 SCREENING QUESTIONNAIRE	YES	NO
Do you have a fever, or have you felt hot or feverish recently?		
Are you having shortness of breath or other difficulties breathing?		
Do you have a cough?		
Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?		
Have you experienced recent loss of taste or smell?		
Are you in contact with any confirmed COVID-19 positive individuals?		
Are you over the age of 60?		
Do you have heart disease, lung disease, kidney disease, diabetes or any autoimmune disorder?		
Have you traveled in the past 14 days to any regions affected by COVID-19?		

I confirm that I am not presenting any of the previously mentioned COVID-19 symptoms.

Signature:_____ **Date:**_____

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Prostho Dental Media Release

I _____ hereby grant permission to Prostho Dental and its agents to use, disclose and reproduce my name and/or initials representing my name, age, my likeness as well as photographs, videotapes and/or recordings ("Images") made of me arising out of my treatment and statements made by me and shown below ("Statements") for promotional materials including brochures, press releases, websites, social media and education materials

and activities of Prostho Dental. I understand the Statements may be used in whole or in part and may be paraphrased, amplified, shortened, or otherwise put into another form to meet the requirements of copy, layout and/or script, provided that the general sense is not changed. I agree that Prostho Dental may use an actor or model to portray me in any materials that utilize the Statements.

I waive all rights to inspect and approve the finished advertising, promotion, educational and publicity materials, using my Statements or Images and I waive any right to royalties or other compensation arising from or related to the use or disclosure of my Images and/or Statements.

I release Prostho Dental and its employees, agents, servants, and trustees from any and all liability (including attorney's fees), loss or untoward results that may occur from including, but not limited to, the use of the above for the above stated purposes.

I acknowledge that I have read and understand the above and agree to be bound by each and every term.

Please Print

Patient's Name: _____

Home Address:
_____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____

Signature: _____

Date: _____