# PATIENT INFORMATION ADULT FORM

Patient Name:_____ Date of Birth:_____

Social Security #_____ TDL #_____

Mailing Address_____

City _____ State _____ Zip _____

Telephone: Home_____ Cell_____

**E Mail Address:_____ ( Used to Confirm appointment )**

Employer Name:_____

Employer Address:_____

Employer Telephone:_____ Your position_____

**Spouse Name:**_____ Date of Birth:_____

Spouse Social Security #_____ TDL #_____

Spouse Cell:_____ Employer:_____

Employer Address: _____

Employer Telephone:_____ Job Position_____

**Dental Insurance Company #1:** _____

Telephone:_____ Group #_____

Insured Name:_____ ID#_____

**Dental Insurance Company #2:** _____

Telephone:_____ Group #_____

Insured Name:_____ ID#_____

## Who may we contact in case of emergency? (Phone Number)_____

(Name)_____ (Relationship)_____

## Do you have any medicine or Latex allergies? **Yes** **No**

**List:**_____

**Do you take Pre Medication before dental work and why?** _____

**Have you ever taken or are you currently taking any blood thinners, i.e. Coumadin** ? Yes No

**List current medications you are taking:** _____

_____

_____

**Who referred you to our office?** _____

# MEDICAL HISTORY

Have you been under the care of a medical doctor during the past two years? Yes No

Have you been a patient in the hospital during the past two years? Yes No

Doctor Name:_____ Telephone Number:_____

Describe:_____

Are you currently taking any medication for Osteoporosis or Osteopenia? Yes No
Are you having dental pain or discomfort at this time? Yes No
Have you ever had a bad experience in the dental office? Yes No
Have you ever had a problem with anesthesia? Yes No
Have you ever been told you have gum disease or need deep cleaning (SRP)? Yes No
Do you use a C-PAP or any kind of sleeping device? Yes No
When was your last dental cleaning and x-rays? _____

**Circle any of the following, which you have had or have at present**:

| | | | |
|---|---|---|---|
| Heart Failure/Attack | Emphysema | Hepatitis A (infectious) | Headaches |
| Heart Surgery | Asthma | Hepatitis B (serum) | Hay Fever |
| Irregular Heartbeat | Cough | Hepatitis C | Sinus Trouble |
| Heart Disease | Tuberculosis (TB) | Glaucoma | Allergies or Hives |
| Angina Pectoris | Stroke | Scarlet Fever | Cortisone or Steroids |
| Mitral Valve Prolapse | Kidney Trouble | Rheumatic Fever | Pain in Jaw Joints Arthritis |
| Heart Murmur | Rheumatism | Yellow Jaundice | Bruise Easily |
| Congenital Heart Lesions | Anemia | Liver Disease | Genital Herpes |
| High Blood Pressure | Ulcers | Epilepsy or Seizures | Syphilis |
| Low Blood Pressure | Thyroid Disease | Cold Sores | Gonorrhea |
| Heart Pacemaker | Diabetes | Fainting or Dizzy Spells | Alcoholism |
| Artificial Heart Valve | Artificial Joint | HIV Positive | Drug Addiction |
| Chemotherapy | Medical pins/ screws | Sickle Cell Disease | Psychiatric Treatment |
| X-ray/ Cobalt Treatment | Blood Transfusion | Hemophilia | Acquired Immune Deficiency Syndrome |

11.) Do you smoke? How Much _____ Yes No

12.) WOMEN: Are you pregnant? Yes No
Are you nursing? Yes No
Are you taking oral contraceptives? Yes No

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have a change in my health or medications I will inform the doctor of dentistry at the next appoint without fail. The undersigned hereby authorizes doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient=s dental needs. I also authorize doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with the patient and further authorize any consent that doctor chooses and employ such assistance as she deems fit. I also understand the use of anesthetic agents embodies a certain risk.

**About Financial Arrangements and Dental Insurance**

We must emphasize that as dental care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility. Delay or failure of an insurance company to pay all or part of a claim is a matter that should be dealt with by the patient directly with the insurance company. The fees we charge for services rendered to those who are insured are our usual and customary fees charged to all patients for similar services. Your policy may base its allowances on a fixed fee schedule, which may or may not coincide with our usual fees. You should be aware that different insurance companies vary greatly in the type of coverage available. Unpaid claims by more than 60 days will then become due by the patient. The 60 days starts from the first day the charges were acquired, whether or not insurance has been filed. There is a $25.00 service charge for return checks and accounts with past due balances over 30 days.
I have read and agree with the above statement.

**I have received a copy of this offices Right to Privacy Act.**

_____

Signature of Patient or Guardian Date

Deborah Jo Gennero, D.D.S., F.A.G.D.
16225 Park Ten Place, Suite 695
Houston, Texas 77084
Email: info@drgennero.com
Telephone: (281) 578-6200 Fax: (281) 578-8858
Cell: (832)524-0522

# Esthetic Evaluation

Name_____ Date_____

Hold a full facial mirror 12-14" from your face. Smile to show your teeth. Take a look at your teeth carefully, and then answer the following questions.

Do you like the overall appearance of your teeth, your smile?
[ ] Yes [ ] No
If NO, please describe_____

Do you consider that your teeth are in good alignment (straight)?
[ ] Yes [ ] No
If NO, please describe_____

Do you have spaces between your teeth that you don't like?
[ ] Yes [ ] No
If YES, please describe_____

Do you like the color of your teeth? [ ] Yes [ ] No

Are you interested in teeth whitening? [ ] Yes [ ] No

Do your teeth have unattractive stains? [ ] Yes [ ] No

[ ] Tobacco stains [ ] Silver filling stains [ ] Coffee/Tea stains
[ ] Discolored fillings [ ] Tetracycline stains [ ]
Other_____

Do you like the shape of your teeth?
[ ] Yes [ ] No
If NO, please describe_____

Do you think that your teeth are attractive [ ] Yes [ ] No
[ ] Chipped [ ] Hidden [ ] Overlapping
[ ] Protruding [ ] excessively worn [ ] Artificial looking

Do you like the way your upper and lower teeth come together? [ ] Yes [ ] No
If NO, please describe_____

Do you consider your existing fillings or dental work as unattractive? [ ] Yes [ ] No
If YES, please describe_____

Do you think your gums are unattractive? [ ] Yes [ ] No
[ ] Swollen [ ] Bleed easily [ ] excessively receded
[ ] Reddened [ ] Crowns are ill-fitting [ ] Difficult to clean between teeth

What would you like to change the most about the appearance of your teeth, your smile?
_____
_____

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# Adult Airway Questionnaire

**Patient Personal Data:**

Name:_____ Age:_____ Date:_____

Gender:_____ Occupation: _____

**Airway Assessment:**

| | | | |
|---|---|---|---|
| Do you breathe through your mouth? | Y | N | Don't Know |
| Do you frequently get a dry throat or non-productive cough? | Y | N | Don't Know |
| Do you have any nasal allergies? | Y | N | Don't Know |
| Do you snore or have you been told you snore while sleeping? | Y | N | Don't Know |
| Do you stop or pause your breathing while sleeping? | Y | N | Don't Know |
| Do you wake up fatigued? | Y | N | Don't Know |
| Do you have morning tension or migraine headaches? | Y | N | Don't Know |
| Do you easily get tired or fall asleep during the day? | Y | N | Don't Know |
| Do you clench or grind the teeth during the night? | Y | N | Don't Know |
| Do you have any facial pain? | Y | N | Don't Know |
| Do you usually drink alcohol or take sleep aids before going to bed? | Y | N | Don't Know |
| Do you suffer from hypertension? | Y | N | Don't Know |
| Have you been diagnosed with: | | | |
| Chronic Fatigue Syndrome | Y | N | Don't Know |
| Irritable Bowel Syndrome | Y | N | Don't Know |
| Fibromyalgia | Y | N | Don't Know |
| Temporomandibular Syndrome | Y | N | Don't Know |
| Have you ever had a sleep study? | Y | N | Don't Know |
| Do you use a cPap? | Y | N | Don't Know |
| Do you have the results to share? | Y | N | Don't Know |
| Did they make you a sleep appliance? | Y | N | Don't Know |
| Do you wear a Nightguard? | Y | N | Don't Know |
| If yes: Has it helped? | Y | N | Don't Know |

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# PHOTOGRAPHY CONSENT FORM / RELEASE

I, _____, hereby grant permission to Deborah Jo Gennero, D.D.S., to take and use: photographs and/or digital images of me for use in website, news releases and/or educational materials. These materials might include printed or electronic publications, Web sites or other electronic communications. I further agree that my name and identity may be revealed in descriptive text or commentary in connection with the image(s). I authorize the use of these images without compensation to me. All negatives, prints, digital reproductions shall be the property of Deborah Jo Gennero, D.D.S.

_____
(Date)

_____
(Signature)

_____
(Address)

_____
(City, State, Zip)

**RELEASE FOR MINOR CHILDREN** (Under 18)

I, _____ , (Print Name)

Parent or official guardian of _____ , (Print Patient Name)

Herby grant permission to Deborah Jo Gennero, D.D.S. to take and use photographs and/or digital images of **my child** for use in news releases and/or educational materials as follows: printed publications or materials, electronic publications, or Web sites. I agree that my child's name and identity: may be revealed in descriptive text or commentary in connection with the image(s). I authorize the use of these images without compensation to me. All negatives, prints, digital reproductions and shall be the property of Deborah Jo Gennero, D.D.S.

_____
(Date)

_____
(Signature of Parent or Guardian)

_____
(Address)

_____
(City, State, Zip)

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# Notice of Privacy Practices for Protected Dental Information

**This notice describes how dental information about you may be used and disclosed and how you can get access to this information. Please review it carefully!**

**With your consent, the practice is permitted by federal privacy laws to make uses and disclosures of your dental information for purposes of treatment, payment, and dental care operations. Protected dental information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.**

**Your Dental Information Rights**

**The dental record we maintain and billing records are the physical property of the practice. The information in it, however, belongs to you. You have a right to:**

**· Request a restriction on certain uses and disclosures of your dental information by delivering the request in writing to our office. We are not required to grant the request but we will comply with any request granted;**

**· Request that you be allowed to inspect and copy your dental record and billing record—you may exercise this right by delivering the request in writing to our office;**

**· Appeal a denial of access to your protected health information except in certain circumstances;**

**Our Responsibilities**

**The practice is required to:**

**· Maintain the privacy of your dental information as required by law;**

**· Provide you with a notice of our duties and privacy practices as to the information we collect and maintain about you;**

**· Abide by the terms of this Notice;**

**We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected dental information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice" or by visiting our office and picking up a copy.**

**To Request Information or File a Complaint**

**If you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the written complaint to Dr. Gennero. You may also file a complaint by mailing it to:**

**The U.S. Department of Health and Human Services**
**200 Independence Avenue, S.W.**
**Washington, D.C. 20201**

**Other Disclosures and Uses**

**Notification**

**Unless you object, we may use or disclose your protected dental information to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death.**

**Communication with Family**

**Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, dental information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency.**

**Food and Drug Administration (FDA)**

**We may disclose to the FDA your protected health information relating to adverse events with respect to products and product defects, or**

**Food and Drug Administration (FDA)**

**We may disclose to the FDA your protected health information relating to adverse events with respect to products and product defects, or**

**post-marketing surveillance information to enable product recalls, repairs, or replacements.**

**Public Health**

**As required by law, we may disclose your protected dental information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.**

**Abuse & Neglect**

**We may disclose your protected dental information to public authorities as allowed by law to report abuse or neglect.**

**Correctional Institutions**

**Law Enforcement**

**We may disclose your protected dental information for law enforcement purposes as required by law, such as when required by a court order, or in cases involving felony prosecutions, or to the extent an individual is in the custody of law enforcement.**

**Health Oversight**

**Federal law allows us to release your protected dental information to appropriate health oversight agencies or for health oversight activities.**

**Judicial/Administrative Proceedings**

**We may disclose your protected dental information in the course of any judicial or administrative proceeding as allowed or required by law, with your consent, or as directed by a proper court order.**

**Other Uses**

**Other uses and disclosures besides those identified in this Notice will be made only as otherwise authorized by law or with your written authorization and you may revoke the authorization as previously provided.**

**Website**

**We maintain a website that provides information about our entity; this Notice will be on the website.**

**Additional Uses and Disclosures**

**Research**

**· We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected dental information.**

**Disaster Relief**

**· We may use and disclose your protected dental information to assist in disaster relief efforts.**

**Funeral Directors/Coroners**

**· We may disclose your protected dental information to funeral directors or coroners consistent with applicable law to allow them to carry out their duties.**

**Marketing**

**· We may contact you to provide you with information about treatment alternatives, or with information about other dental-related benefits and services that may be of interest to you.**

**For Specialized Governmental Functions**

**· We may disclose your protected dental information for specialized government functions as authorized by law, such as to Armed Forces personnel, for national security purposes, or to public assistance program personnel.**

_____ _____

**Signature** **Date**