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

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

	Yes	No		Yes	No
Is your past and present health good?	<input type="checkbox"/>	<input type="checkbox"/>	Do you <input type="checkbox"/> smoke <input type="checkbox"/> chew <input type="checkbox"/> dip	<input type="checkbox"/>	<input type="checkbox"/>
Are you pregnant/nursing?	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had to premedicate with antibiotics prior to Dental Care?	<input type="checkbox"/>	<input type="checkbox"/>
Are you allergic to any medications?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Aspirin <input type="checkbox"/> Penicillin <input type="checkbox"/> Codeine <input type="checkbox"/> Acrylic <input type="checkbox"/> Metal					
<input type="checkbox"/> Latex Rubber <input type="checkbox"/> Dental anesthesia, gas or novocaine					
<input type="checkbox"/> Other _____					

Dental- Periodontal History

	Yes	No		Yes	No
Have you ever been treated for periodontal problems before? If so, when? _____	<input type="checkbox"/>	<input type="checkbox"/>	When was your last Dental Cleaning? _____		
Unpleasant taste and/or odor in your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have pain/sensitivity in your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Is there any family history of periodontal problems?	<input type="checkbox"/>	<input type="checkbox"/>	Brush _____ times a day with:		
Do your gums bleed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Soft <input type="checkbox"/> Medium <input type="checkbox"/> Hard brush.		
Do you have pain in your gums?	<input type="checkbox"/>	<input type="checkbox"/>	Is your toothbrush hand held or electric? _____		
Do you gag easily?	<input type="checkbox"/>	<input type="checkbox"/>	Floss _____ times a day with:		
Do your gums feel swollen?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Unwaxed <input type="checkbox"/> Waxed <input type="checkbox"/> by Hand <input type="checkbox"/> Holder		
Please list any medications you are taking and their dosages: _____			Brush & floss: <input type="checkbox"/> Morning <input type="checkbox"/> Noon <input type="checkbox"/> After Dinner <input type="checkbox"/> Bedtime		

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 preceding 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 _____

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
