Peter O. Cabrera, DDS
Bahareh Sabzehei, DDS, MS

Practice Limited to Periodontics
Dental Implants * Soft Tissue Reconstruction

Name	_____	Date of Birth	_____
Home Address	_____	Home Phone	_____
City/Zip	_____	Work Phone	_____
E-Mail Address	_____	Cell Phone	_____
Social Security #	_____	Marital Status	❑ Single ❑ Married
Occupation	_____	Name of Spouse	_____
Referred By	_____	General Dentist	_____

Emergency Contact (Name, Relation, Phone) _____

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT YOUR GENERAL HEALTH:

1. What is your impression of your general health? _____
2. When was the last time you were examined by a physician? _____
3. What is your physician's name? _____
4. Please circle any of the following which your have had or have now:

AIDS / HIV Positive	Chest Pains	Injury to Face / Jaw
Allergies	Cortisone / ACTH	Kidney Problems
Anemia	Diabetes	Lung Problems
Angina Pectoris	Epilepsy / Seizures	Operations
Arthritis	Fainting / Dizzy Spells	Prolonged Bleeding
Artificial Heart Valve	Heart Disease	Psychiatric Treatment
Artificial Joint	Heart Murmur	Rheumatic Fever
Asthma	Hepatitis	Tuberculosis
Cancer	High Blood Pressure	Ulcer

Yes or No Have you been under a physician's care within the last year?
If yes, for what? _____

Yes or No Are you presently taking any medications?
If yes, which ones? _____

Yes or No Are you presently taking any herbal or vitamin supplements?

If yes, which ones? _____

Yes or No Are you allergic to any medications or materials?
If yes, which ones? _____

Yes or No Have you ever had a reaction to a local anesthetic?

Yes or No Have you ever had complications from any dental treatment?

Yes or No Do you have any diseases/conditions not listed above?

Yes or No Have you ever been told that you were not eligible to give blood?

Yes or No Women: Are you pregnant? If yes, what trimester? _____

Yes or No Are you presently having problems in your mouth or involving your face?
If yes, please explain _____

Yes or No Do you use tobacco? If yes, how much and what type? _____

Yes or No Have you ever had treatment for gum disease?

Yes or No Have you ever had orthodontic treatment? If yes, at what age? _____

Periodontal (gum) infections can have several symptoms. Do you have any of the following:

❑ Bleeding Gums ❑ Swollen Gums ❑ Receding Gums
❑ Sensitivity to hot/cold ❑ Loose Teeth ❑ Halitosis (Bad Breath)

Periodontal (gum) diseases can have a genetic component.

Yes or No Do any of your relatives (parents, brothers, sisters, children) have periodontal problems?

Yes or No Have they complained of any of the above named symptoms?

Certain periodontal bacteria can be transmitted among family members.

Yes or No Have any of your immediate family members been diagnosed with periodontal disease?

Yes or No If you have any missing teeth or any teeth can't be saved, are you interested in replacing them with dental implants?

Dental Insurance Information

Yes or No Do you have dental insurance?

Subscriber Name_____

Employer Name _____

Employer Address _____

City/State/Zip_____

Insurance Name_____

Insurance Address _____

City/State/Zip_____

Insurance Phone _____

Group Number_____

Subscriber ID#/SSN_____

Subscriber DOB_____

Have you utilized your dental insurance for other dental work this calendar year? Yes ___ No ___

If yes, what treatment was provided and by whom? _____

Additional Comments: _____

_____

Patient's Signature _____ Date _____
(If *patient is unable to sign or is a minor, then signature of parent or legal guardian.)*

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PATIENT'S ACKNOWLEDGEMENT
OF
RECEIPT OF NOTICE OF PRIVACY POLICY

I, _____, have received a copy of the Notice of Privacy Practices of the office of Peter O. Cabrera, DDS.

OPTING OUT

- ☐ Do not leave appointment reminder messages on my home answering system.
- ☐ Do not leave appointment reminder messages at my place of employment.
- ☐ Do not contact my place of employment under any circumstance.
- ☐ I do not wish my protected health care information to be released to the following persons:_____.

Patient Signature _____ Date _____

Printed Name _____

☐ I decline to sign this Acknowledgment.

FOR OFFICE USE ONLY

Received By _____ Date _____

☐ The office was unable to obtain a signed Acknowledgment form from the above patient for the following reasons: