HEALTH QUESTIONNAIRE

Patient Name: _____ Date_____

D.O.B.:_____ Sex:_____ Height:_____ Weight:_____

Directions

Please check the appropriate answer to the questions and fill in the blanks where indicated. Answer all questions and blanks completely. Answers to the following questions are for records and will be considered confidential.

1. Are you in good health?_____ ☐ Yes ☐ No
   A. Has there been any changes in your general health? ☐ Yes ☐ No
2. My last physical examination was on:_____
   _____
3. Are you now under the care of a physician?_____ ☐ Yes ☐ No
4. The name and address of my physician is:_____
   _____ ☐ Yes ☐ No
5. Have you ever had a serous illness or operation?_____
6. Have you been hospitalized with any of the following ☐ Yes ☐ No
   within the last five (5) years?_____ ☐ Yes ☐ No
   A. Do you have a persistent cough or cough up blood? ☐ Yes ☐ No
   B. Low/High blood pressure (circle one)_____ ☐ Yes ☐ No
   C. Veneral Disease_____ ☐ Yes ☐ No
   D. AIDS or HIV+_____ ☐ Yes ☐ No
   E. Other_____
   _____
7. Have you had abnormal bleeding associated with previous extractions, surgery, or trauma?_____ ☐ Yes ☐ No
   If yes, explain the circumstances_____
   _____
8. Do you have any blood disorder such as anemia? ☐ Yes ☐ No
9. Have you had surgery or x-ray treatment for a tumor, growth or other condition of your mouth or lips?_____ ☐ Yes ☐ No
10. Are you taking any drug or medication?_____
    If yes, what_____
    _____
11. Are you taking any of the following:
    A. Antibiotics or sulfa drugs _____ ☐ Yes ☐ No
    B. Anticoagulants (blood thinners)_____ ☐ Yes ☐ No
    C. Medicine for high blood pressure_____ ☐ Yes ☐ No
    D. Cortisone (steroids)_____ ☐ Yes ☐ No
    E. Tranquilizers_____ ☐ Yes ☐ No
    F. Aspirin_____ ☐ Yes ☐ No
    G. Insulin, Tolbutamide (Orinase) or similar drug_____ ☐ Yes ☐ No
    H. Digitalis or drugs for hear trouble_____ ☐ Yes ☐ No
    I. Nitroglycerin_____ ☐ Yes ☐ No
    J. Fen-Phen (now or in the past) or related drug such lonimin, Adipex, Phentemine, Fastin, Pondimin (Fenfluramine), and Redux (dexfenfluramine)_____ ☐ Yes ☐ No
    K. Oral Contraceptives_____ ☐ Yes ☐ No
    If yes, what are you using?_____
    _____
    L. Chemotherapy Drugs_____ ☐ Yes ☐ No
    M. Osteoporosis Drugs (Fosamax, etc.)_____ ☐ Yes ☐ No
    N. Other_____
    _____
12. Do you have a heart murmur/mitral valve prolapse? ☐ Yes ☐ No
13. Do you have any implants and/or Prosthesis (i.e. knee joints, elbow pins, etc.)?_____ ☐ Yes ☐ No
14. Do you drink alcoholic beverage?_____ ☐ Yes ☐ No
15. Do you smoke?_____ ☐ Yes ☐ No
    If yes, how much?_____
16. Do you have, or have you had, any of the following diseases or problems?
    A. Rheumatic fever or rheumatic heart disease__ ☐ Yes ☐ No
    B. Congenital heart lesions_____ ☐ Yes ☐ No
    C. Cardiovascular disease (heart trouble, heart attack, coronary occlusion, high blood pressure, arteriosclerosis, stroke)_____ ☐ Yes ☐ No
       1. Do you have pain in the chest upon exertion? ☐ Yes ☐ No
       2. Are you ever short of breath after mild exercise? ☐ Yes ☐ No
       3. Do you get short of breath when you lie down or do you require extra pillows when you sleep?_____ ☐ Yes ☐ No
    D. Allergy_____ ☐ Yes ☐ No
    E. Asthma or hay fever_____ ☐ Yes ☐ No
    F. Hives or skin rash_____ ☐ Yes ☐ No
    G. Fainting spells or seizures_____ ☐ Yes ☐ No
    H. Diabetes_____ ☐ Yes ☐ No
       1. Do you have to urinate (pass water) more than six (6) times a day?_____ ☐ Yes ☐ No
       2. Are you thirsty much of the time?_____ ☐ Yes ☐ No
       3. Does your mouth frequently become dry?_ ☐ Yes ☐ No
    I. Hepatitis, jaundice, or liver disease_____ ☐ Yes ☐ No
    J. Arthritis_____ ☐ Yes ☐ No
    K. Inflammatory rheumatism (painful, swollen joints)_____ ☐ Yes ☐ No
    L. Stomach ulcers_____ ☐ Yes ☐ No
    M. Kidney trouble_____ ☐ Yes ☐ No
    N. Tuberculosis_____ ☐ Yes ☐ No
17. Are you allergic or have you reacted adversely to:
    A. Local anesthetic_____ ☐ Yes ☐ No
    B. Penicillin or other antibiotics_____ ☐ Yes ☐ No
    C. Barbiturates, sedatives, or sleeping pills_____ ☐ Yes ☐ No
    D. Sulfa Drugs_____ ☐ Yes ☐ No
    E. Aspirin_____ ☐ Yes ☐ No
    F. Iodine_____ ☐ Yes ☐ No
    G. Latex_____ ☐ Yes ☐ No
    H. Other_____ ☐ Yes ☐ No
    _____
18. Have had any serious trouble associated with previous dental treatment?_____ ☐ Yes ☐ No
    If yes, explain_____
    _____
19. Are you pregnant or could you be?_____ ☐ Yes ☐ No
    If yes, when are you due?_____

I certify to the best of my knowledge that the above information is correct and that if there are any changes in the above, I agree to notify my dentist before my next visit.

_____
Patient/Guardian Signature Date

_____
Doctor Signature Date

Updates:

_____ / /
Patient/Guardian Signature DDS/hyg Date

_____ / /
Patient/Guardian Signature DDS/hyg Date

_____ / /
Patient/Guardian Signature DDS/hyg Date

WELCOME

(661) 395-3115
(661) 327-0679 Fax
www.sangerdds.com

MARTHA H. SANGER, D.D.S., INC.
Practice limited to Periodontics
With services in Dental Implants

2320 17th Street
Bakersfield, CA 93301
E-mail: sangerdds@yahoo.com

Periodontics & Implants

PATIENT INFORMATION

NAME First_____ MI_____ Last_____
ADDRESS Street_____ City_____ State_____ Zip_____
Home Phone_____ Work Phone_____ Single_____ Married_____ Divorced_____ Widowed_____
Employer_____ Occupation_____
Soc Sec #_____ Date of Birth_____ Driver's License #_____
Patient's Dentist_____ Referred By_____
Cell Phone: _____ E-mail: _____

Spouse's Information
(or parent, if patient is a minor)
Spouse's Name_____
Employer_____
Occupation_____ Wk #_____
Soc Sec #_____ Birthdate_____

RELATIVE NOT LIVING WITH YOU
(for emergency purposes)
Name_____
Address_____
City_____ State_____ Zip_____
Phone_____ Relationship_____

PRIMARY DENTAL INSURANCE INFORMATION
Policy Owner's Name_____
Soc Sec #_____ Birthdate_____
Insurance Co_____ Group #_____
Ins Co Address_____
Employer_____
I authorize the release of any information relating to the submission of dental claims.

_____
Signed (patient or parent, if minor) Date

SECONDARY DENTAL INSURANCE INFORMATION
Policy Owner's Name_____
Soc Sec #_____ Birthdate_____
Insurance Co_____ Group #_____
Ins Co Address_____
Employer_____
I hereby authorize payment directly to Martha H. Sanger, D.D.S., Inc. of insurance benefits otherwise payable to me.

_____
Signed (patient or parent, if minor) Date

To avoid misunderstanding regarding dental insurance, we wish our patients to know that ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED DIRECTLY TO PATIENT and that PATIENTS ARE PERSONALLY RESPONSIBLE FOR PAYMENT OF FEES. We will prepare necessary forms or reports to help you obtain your benefits from insurance companies. We do not render our services on the basis that insurance companies will pay our fees.

DENTAL HEALTH HISTORY

Has your dental care been: ☐ regular ☐ when necessary ☐ when in pain? Approximate date teeth last cleaned_____
Are you in pain? ☐ yes ☐ no Are you apprehensive about visiting our office? ☐ yes ☐ no
Have you ever had: ☐ gum disease ☐ braces ☐ root canal ☐ implants? If so, when? _____
Are you dissatisfied with the appearance of your teeth? ☐ yes ☐ no
Have you ever had any of the following? (check all those that apply)

☐ bleeding gums ☐ food packing between teeth ☐ clenching or grinding ☐ spaces between teeth
☐ receding gums ☐ swelling of gums ☐ high or rough fillings ☐ bad breath
☐ drifting of teeth ☐ pus around teeth ☐ soreness or pain in gums

Do you have any sensitivity to any of the following? (check all those that apply)
☐ hot ☐ cold ☐ biting ☐ pressure ☐ sweet ☐ toothbrushing
Have you ever had an injury to your face, neck or jaws? ☐ yes ☐ no
Do you suffer from pain in your face, neck or jaws? ☐ yes ☐ no

Pharmacy Info:
Name:_____
Phone No. _____

Martha H. Sanger, D.D.S.
Periodontics & Dental Implants

WE'RE CONCERNED ABOUT YOU

We understand that you are unique and have unique concerns. You may also have special needs for treatment given your medical history. So that we can provide you with the best possible care, please check off the statements that apply to you. Sincerely, Martha Sanger, DDS

Name: _____ **Date:** _____

		Yes	No
1.	I am nervous being in a dental chair.	____	____
2.	I have had a bad experience in a dental office.	____	____
3.	I sometimes get dizzy lying back in a dental chair.	____	____
4.	I have had difficulty with gagging or suctioning.	____	____
5.	I would like to take breaks during long appointments.	____	____
6.	My teeth or gums are very sensitive.	____	____
7.	I don't like dental noises such as drilling or suctioning.	____	____
8.	I don't like shots (or have had a bad experience with them).	____	____
9.	I would like extra care to relieve pain.	____	____
10.	I am not comfortable being lectured to by doctors.	____	____
11.	I will need to relay what you tell me to my spouse or another.	____	____
12.	I have concerns about appointment scheduling.	____	____
13.	I have concerns about the appearance of my teeth or smile.	____	____
14.	I have concerns about eating, chewing, or bad breath.	____	____
15.	I have concerns about insurance or finances.	____	____
16.	I have another question or concern. (Please write it below.)	____	____

_____

17. Please check off if you (or a family member) have any history of the following:

	Yourself	*Parents*	*Grandparents*
A. Alzheimer's Disease	____	____	____
B. Blood Cancer	____	____	____
C. Diabetes	____	____	____
D. Heart Attack	____	____	____
E. Heart Disease	____	____	____
F. Kidney Cancer	____	____	____
G. Lung Cancer	____	____	____
H. Lung Disease	____	____	____

	Yourself	*Parents*	*Grandparents*
I. Obesity	____	____	____
J. Osteoporosis	____	____	____
K. Pancreatic Cancer	____	____	____
L. Premature Childbirth	____	____	____
M. Stroke	____	____	____
N. Tongue Cancer	____	____	____
O. Other Cancers	____	____	____
P. Tooth Loss/Dentures	____	____	____

2320 17th Street, Bakersfield, CA 93301
Tel (661) 395-3115 Fax (661) 327-0679 www.sangerdds.com

MEDICAL RISKS & PERIODONTAL DISEASE

4 WAYS PERIODONTAL INFECTION CAUSES MEDICAL PROBLEMS

1. **BLOOD STREAM** - ***Chewing Injects Infectious Bacteria into Your Blood Stream.***
   Periodontal bacteria in the blood stream increased 4 times (24%) in those who chewed just 50 times.[11]
2. **BREATHING** - ***Periodontal Bacteria Are Breathed into Your Lungs.***
   Periodontal bacteria can be breathed into the lungs and increase the incidence of lung disease.[14]
3. **IMMUNE SYSTEM** - ***Periodontal Infection Can Lower Your Immune System.***
   A study has found that health care costs were 21% higher for those patients with severe periodontal disease.[15]
4. **TRANSMISSION** - ***Periodontal Infection Is Transmitted to Your Spouse & Children.***
   DNA tests show that periodontal infection is transmitted directly from spouse to spouse and parent to child.[2]

RESEARCH FINDINGS

ALZHEIMER'S – *DETERMINING FACTOR*
Gum disease early in life, less education, and a history of stroke are more important than genes in determining who develops dementia, concluded a study of 100 dementia patients with healthy identical twins.[4]

BLOOD CANCERS – *30% MORE RISK*
A demographic study of nearly 50,000 men showed that those with periodontal disease had a 30% higher risk of blood cancers, including: leukemia, multiple myeloma and non-Hodgkin lymphoma.[7]

DIABETES – *INCREASED SEVERITY*
Periodontal disease affects blood sugar control, lengthens the duration of diabetic symptoms, and speeds the transition from pre-diabetes to diabetes.[12]

DIABETES – *2.8 - 3.4 TIMES MORE RISK*
Diabetic patients are 2.8 to 3.4 times more likely to have periodontal disease.[5]

HEART ATTACK – *2.7 TIMES MORE RISK*
Demographic studies of 1,372 subjects showed those with periodontal disease were 2.7 times more likely to have a heart attack.[8]

HEART DISEASE – *40–72% MORE RISK*
Demographic studies of 10,907 subjects showed a 40% to 72% increased risk of heart disease.[11]

KIDNEY CANCER – *49% MORE RISK*
A demographic study of nearly 50,000 men showed that those with periodontal disease had a 49% higher risk of kidney cancer.[7]

LUNG CANCER – *36% MORE RISK*
A demographic study of nearly 50,000 men showed that those with periodontal disease had a 36% higher risk of lung cancer.[7]

LUNG DISEASE – *1.5 TIMES MORE RISK*
In a demographic study of 13,792 individuals, those with periodontal disease had a 1.5 times greater risk of getting chronic obstructive pulmonary disease.[14]

OBESITY – *76% HIGHER IN YOUNG ADULTS*
In a study of 13,665 young adults (18-34) who had periodontal disease, 76% were more likely to be obese.[13]

OSTEOPOROSIS – *TREATMENT LINK*
Research has shown that treating osteoporosis can lower the severity of periodontal disease.[1]

PANCREATIC CANCER – *63% MORE RISK*
In a study of 51,529 males, it was found that men with periodontal disease had a 63% to 126% higher risk of pancreatic cancer.[9]

PREMATURE CHILDBIRTH – *79% HIGHER*
Premature low birth-weight childbirth greatly increases complications. Women with untreated periodontal disease have a 79% higher chance of premature childbirth. Treatment gives an 84% reduction in premature births.[6]

STROKE – *BACTERIA IN BLOOD CLOTS*
Periodontal bacteria have been found in blood clots and those with periodontal disease have a higher risk of stroke.[10]

TONGUE CANCER – *5 TIMES MORE RISK*
Men with advanced periodontal disease have more than five times the risk of tongue cancer.[3]

Compliments of
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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 15, 2003 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: 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 anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure you health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the persons's involvement in you healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose you health information to appropriate authorities if we reasonably believe that you are possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you .15¢ for each page. $15.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request any alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are no required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTION AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of health and Human Services upon request.

We support your right to the privacy of yourhealth information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: **Steve Sanger**

Telephone: **(661) 395-3115**

Fax: **(661) 327-0679**

Address: **2320 17th Street**

Bakersfield, CA 93301

This Form is educational only, does not constitute legal advice, and covers only federal, not state law (August 14, 2002)

Martha H. Sanger, D.D.S., Inc.
2320 17th Street
Bakersfield, CA 93301

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgments *

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgments could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other (Please Specify)

_____

_____

_____