Mark I. Handelsman, D.D.S. Inc.
1245 Sixteenth Street #206 Santa Monica CA 90404
(310)829-7550 markhandelsmandds.com

Name_____ Date of Birth_____

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Residence Address_____ Home Phone _____

City, State, Zip_____ Cell Phone _____

Email _____ Preferred method of contact? ☐ Cell # ☐ Home # ☐ Email

☐ I consent to receiving correspondence regarding appointments and treatment options via email.

Employed by _____ Business Address_____

Present Position_____ Business Phone _____

Social Security # _____ Drivers License Number _____

Spouse's Name _____

Spouse Employed by _____ Business Address_____

Spouse's Present Position_____ Business Phone _____

Dental Insurance Carrier: Primary _____ Group # _____

Dental Insurance Carrier: Secondary _____ Group # _____

Name of Insured _____ Date of Birth_____ SS#_____

Who may we thank for this referral? _____

Your Dentist's Name _____ Phone _____

Your Dentist's Address _____

Who may we contact in case of an emergency? _____ Phone _____

All accounts are due and payable at time of service rendered, unless prior arrangements have been made. If it is desirable to extend payments for more than 30 days, specific arrangements must be made with our office. These extended payment courtesies are made at no interest or finance charge provided payments are received as promised.

To avoid misunderstandings regarding dental insurance, we wish our patients to know that *all professional services rendered are charged directly to the patient* and that *patients are personally responsible for payment of fees.* We will prepare the necessary forms or reports to help you obtain your benefits from insurance companies. We do not render out services on the basis that insurance companies will pay our fees.

CONSENT FOR PERIODONTAL SERVICES

"I hereby authorize and request the above named doctor and his auxiliaries to perform for me all periodontal therapy and surgery indicated in my dental records and to do whatever procedures are deemed advisable in his/her judgment. I will discuss any aspect of my treatment I do not understand with my periodontist. I acknowledge that the benefits and risks of periodontal therapy are understood prior to accepting treatment."

"I also authorize and request the administration of such drugs and/or anesthetics as may be deemed advisable by the above named doctor."

"It has been explained to me, and I understand, that results are not, and cannot be, guaranteed or warranted."

I authorize this office to obtain or release information pertaining to my care to my other dental providers.

I have had an opportunity to review the "Notice of Privacy Practices."

So that we may assure you and other patients of uninterrupted treatment, *it is necessary for all patients to accept and adhere to a definite arrangement of appointments and fees.*

Once an appointment is made, please remember that this time is reserved for you: at least 48 hours prior, the office will contact you to review screening questions. Notice must be given if cancellation is absolutely necessary, otherwise cancellation charges may apply. *Cancellations due to any symptoms related to Covid-19 will not incur charges.*

I have read and understand the above.

Date _____ Signed _____

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It is important that we know about your dental and medical history, as many things have a direct bearing on your periodontal health. Please fill out the questionnaire fully. The information you give us is confidential and will not be released without your permission.

DENTAL HISTORY

Are you having pain or discomfort at this time? _____ ☐ YES ☐ NO

Do you feel very nervous about having dental treatment?_____ ☐ YES ☐ NO

Have you ever had a bad experience in the dental office?_____ ☐ YES ☐ NO

Why are you seeking dental care at this time? _____

Date of last professional dental cleaning: _____ How often do you usually have your teeth cleaned?_____

MEDICAL HISTORY

Are you under a physician's care now? ☐ YES ☐ NO

Physician's Name_____ Address _____ Phone_____

Date of last physical exam: _____ Date of last visit _____

Are you now in good health? _____

Are you taking any medication? ☐ YES ☐ NO | if yes, What? _____

Have you ever been hospitalized? ☐ YES ☐ NO | if yes, for what? _____ Date_____

Do you take aspirin frequently? _____ Are you on a special diet? _____

Do you currently use tobacco? ☐ YES ☐ NO Have you ever? ☐ YES ☐ NO | if yes, how many years? _____

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Other _____

Do you have, or have you had, any of the following?

☐ AIDS/HIV Positive
☐ Alzheimer's Disease
☐ Anaphylaxis
☐ Anemia
☐ Angina
☐ Arthritis/Gout
☐ Artificial Heart Valve
☐ Artificial Joint*
☐ Asthma
☐ Blood Disease
☐ Blood Transfusion
☐ Breathing Problem
☐ Bruise Easily
☐ Cancer
☐ Chemotherapy
☐ Chest Pains
☐ Cold Sores/Fever Blisters
☐ Congenital Heart Disorder
☐ Convulsions
☐ Cortisone Medicine
☐ Diabetes
☐ Drug Addiction
☐ Easily Winded
☐ Emphysema
☐ Epilepsy or Seizures
☐ Excessive Bleeding
☐ Excessive Thirst
☐ Fainting Spells/Dizziness
☐ Frequent Cough
☐ Frequent Diarrhea
☐ Frequent Headaches
☐ Genital Herpes
☐ Glaucoma
☐ Hay Fever
☐ Heart Attack/Failure
☐ Heart Murmur
☐ Heart Pace Maker
☐ Heart Trouble/Disease
☐ Hemophilia
☐ HepatitisA
☐ Hepatitis B or C
☐ Herpes
☐ High Blood Pressure
☐ Hives or Rash
☐ Hypoglycemia
☐ Irregular Heartbeat
☐ Kidney Problems
☐ Leukemia
☐ Liver Disease
☐ Low Blood Pressure
☐ Lung Disease
☐ Mitral Valve Prolapse
☐ Pain in Jaw Joints
☐ Parathyroid Disease
☐ Psychiatric Care
☐ Radiation Treatments
☐ Recent Weight Loss
☐ Renal Dialysis
☐ Rheumatic Fever
☐ Rheumatism
☐ Scarlet Fever
☐ Shingles
☐ Sickle Cell Disease
☐ Sinus Trouble
☐ Spina Bifida
☐ Stomach/Intestinal Disease
☐ Stroke
☐ Swelling of Limbs
☐ Thyroid Disease
☐ Tonsillitis
☐ Tuberculosis
☐ Tumors or Growths
☐ Ulcers
☐ Venereal Disease
☐ Yellow Jaundice

Have you ever had any serious illness not listed above? ☐ YES ☐ NO | if yes, What?_____

Have you ever taken Fosamax, Boniva, Actonel or any other bisphosphonates? ☐ YES ☐ NO
Have you ever taken any antiresorptive bone medications? ☐ Aredia ☐ Xgeva ☐ Zometa ☐ Prolia ☐ Reclast

Women: Are you ☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives

COVID-19: ☐ Positive ☐ Negative for SARS—CoV-2 Date Tested_____
☐ Positive ☐ Negative for Antibody Date Tested_____

Date _____ Signed _____ Reviewed by _____