Patient Registration

☐ Mr ☐ Ms ☐ Mrs ☐ Dr

First Name ____________________ MI ____

Last Name ____________________

Date of Birth ____________ SSN ____________

Occupation ____________________

Address ____________________

Home Phone ____________________

City ____________ State ________ Zip ________

Work Phone ____________________

ER Contact ____________________

Mobile Phone ____________________

Employer ____________________

Email ____________________

Dentist ____________________

Referred by ____________________

Primary **Dental Insurance** ____________________

Address ____________________ POBOX ________

City ____________ State ________ Zip ________

Group ____________ Phone ____________

Employer ____________________

Employee's Name ____________________

Employee's DOB ____________ SSN ____________

Secondary **Dental Insurance** ____________________

Address ____________________ POBOX ________

City ____________ State ________ Zip ________

Group ____________ Phone ____________

Employer ____________________

Employees's Name ____________________

Employee's DOB ____________ SSN ____________

Privacy Notice, Authorization for Release of Protected Health Information (PHI) and Signature on File:
Dr. Kiurtsidis and his representatives follow state and federal laws to safeguard patient's privacy. I authorize Dr. Kiurtsidis, or his representatives, to release to health care providers and/or health service plans and insurance companies any and all information and records (including x-rays) about my medical history, services rendered or treatment given to me, that is needed to review, investigate or evaluate any claim for benefits. I also authorize Dr. Kiurtsidis to affix my name to any and all claims or documents related to any and all health benefits. If my coverage requires it, this authorization permits disclosure to appropriate entities for purposes of utilization review or financial audit. By signing this registration form, I acknowledge that I have either received or accessed Privacy Notice at http://myperio.com/privacy.html. I have the right to receive a paper copy of this authorization and Privacy Notice disclosing how Dr. Kiurtsidis and his representatives may use or disclose PHI, if requested.

Cancellations & Service Charges:
All appointment changes require 2 day notice. In the case of default payment or no show, I promise to pay 1.5% a month interest on the balance due, together with any costs and fees incurred to effect collection.

Payment:
I authorize Dr. Kiurtsidis' office to assist me in obtaining my dental insurance benefits. I understand that my dental insurance is a contract between me, my employer and the insurance carrier. Regardless of the expected or implied insurance benefits, I am ultimately responsible for the entire balance of my account. All balances be paid in full at the time of the treatment. As a courtesy, Dr. Kiurtsidis' office will process insurance claims on my behalf and *insurance reimbursements will be made directly to me.*

X ____________________

Signature Date

Georgios Kiurtsidis MD DDS 595 Buckingham Way Suite 320 San Francisco CA 94132 415-242-9999 Fax 415-520-9998 MyPerio.com

Medical & Dental History

Name ______________________

Physician ______________________
Address ______________________
Phone ______________ Fax ______________
Last exam ______ Height ______ Weight ______ Age ______
Current treatment for ______________________

Dentist ______________________
Address ______________________
Phone ______________ Fax ______________
Last exam ______ Last cleaning ______ Frequency ____ /Y
Current treatment for ______________________
I brush ____ /d, floss ____ /w & use manual or electric toothbrush

Y	N	Check any *past* or *current* **medical** conditions:
☐	☐	Abnormal bleeding
☐	☐	Anemia
☐	☐	Asthma
☐	☐	Arthritis
☐	☐	Blood transfusion
☐	☐	Cancer/Chemotherapy/Radiation/IV Bisphosphonate
☐	☐	Diabetes
☐	☐	Diet pills Fen-Phen, Redux, Pondimin
☐	☐	Difficulty breathing/Chest pains
☐	☐	Drug/Alcohol abuse
☐	☐	Emphysema
☐	☐	Epilepsy/Seizures
☐	☐	Fainting spells
☐	☐	Fever blisters
☐	☐	Glaucoma
☐	☐	Heart arrhythmia
☐	☐	Heart disease
☐	☐	High blood pressure BP ______ Pulse ______
☐	☐	Low blood pressure
☐	☐	Heart murmur/Mitral valve prolapse/Rheumat. fever
☐	☐	Heart surgery/Pacemaker
☐	☐	Hepatitis
☐	☐	Herpes
☐	☐	HIV+/AIDS
☐	☐	Hospitalization
☐	☐	Joint replacement
☐	☐	Kidney problems
☐	☐	Liver problems
☐	☐	Neck/Back/Joint problems
☐	☐	Psychiatric problems
☐	☐	Severe headaches
☐	☐	Shingles
☐	☐	Sinus problems
☐	☐	Skin problems
☐	☐	Stroke
☐	☐	Surgeries
☐	☐	Tobacco use ______ /day for ______ years
☐	☐	Tachycardia
☐	☐	Thyroid problems
☐	☐	Tuberculosis
☐	☐	Ulcers/Colitis
☐	☐	Venereal disease
☐	☐	Women: Pregnant/Nursing
☐	☐	Women: Birth control pills

Y	N	Check any *past* or *current* **dental** conditions:
☐	☐	Bad breath
☐	☐	Bleeding gums
☐	☐	Dry mouth
☐	☐	Infection in mouth
☐	☐	Interested in dental implants
☐	☐	Jaw problems
☐	☐	Loose teeth
☐	☐	Nervousness during dental treatment
☐	☐	Orthodontic treatment
☐	☐	Pain/Discomfort related to mouth
☐	☐	Receding gums
☐	☐	Scaling & Root planing M/Y ______
☐	☐	Sensitive teeth to cold, hot, sweet, etc.
☐	☐	Spaces between the teeth
☐	☐	Surgical perio treatment M/Y ______
☐	☐	Have you been told by your physician to take **antibiotics** prior to having dental treatment?
☐	☐	Are you **allergic** to any of the following:
☐	☐	Amoxicillin/Penicillin
☐	☐	Aspirin/Advil/Motrin
☐	☐	Codeine
☐	☐	Erythromycin
☐	☐	Latex
☐	☐	Sulpha
☐	☐	Tetracycline
☐	☐	Other ______

Other conditions and concerns not mentioned above:

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List all **medications** & over-the-counter products:

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Notes: ______________________

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X ______________________
Signature Date Reviewed