Christina Gasper, DDS MS
450 Sutter Street, Suite 2336
San Francisco, CA 94108
415 986 4664 T 415 986 1798 F
www.christinagasper.com

Patient Registration

Today's Date _____

☐ Mr.
☐ Mrs.
☐ Dr.
☐ Ms. _____ Name you like to be called _____ Referred by _____

Address _____ City _____ Zip _____

Home Phone (_____)_____ Home FAX (_____)_____

Work Phone (_____)_____ Cell Phone (_____)_____

Date of Birth _____ Age _____ E-mail _____

Employer Name _____

Occupation _____ Length of Employment _____

Business Address _____

City _____ Zip_____

Name of Spouse/Partner_____ Occupation _____

Employed by _____ Length of Employment _____

YOUR PHYSICIAN: _____YOUR DENTIST: _____

Address _____ Address_____

Phone (_____)_____ Phone (_____)_____

PERSON TO CONTACT IN AN EMERGENCY:

Name_____ Relationship_____

Home Address_____

Primary Phone (_____)_____ Secondary Phone (_____)_____

PARTY RESPONSIBLE FOR PAYMENT OF ACCOUNT _____

Address _____City _____State_____ Zip_____

Primary Phone (_____)_____ Secondary Phone (_____)_____

IF YOU HAVE DENTAL INSURANCE, PLEASE FILL OUT THE DENTAL INSURANCE INFORMATION FORM. THANK YOU.

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Dental Insurance Information

We are always happy to assist our patients in obtaining their available benefits with their third party dental insurance plans. Dental insurance is a contracted benefit between the patient, her/his employer, and the insurance carrier. At no time is the insurance carrier obligated to pay benefits to the periodontal/implant practice. The patient or patient's guardian is responsible for the entire balance of their account regardless of expected or implied insurance benefits. As a courtesy to you, we will process your third party claims for major treatment and instruct your carrier to pay you directly. Should the dental insurance carrier inadvertently send payment to our office, we will return it to the carrier with a request that the check be reissued directly to you. Should the dental insurance carrier require x-rays to support the dental claim and your x-rays are film-based (not digital), your films will be outsourced to a commercial x-ray laboratory for processing. You will be advised of the fee from the laboratory at the time of the request and will be responsible for the cost associated with the duplication.

Insured's Name _____

Insured's Birth Date_____ Insured's ID or Social Security Number_____

Patient's ID or Social Security Number_____

Insured's Employer _____

Insurance Company_____Group No._____Local No._____

Insurance Co. Address & Phone No.:_____

_____

Do you have dual insurance coverage? Yes ☐ No ☐ If yes, please complete:

Insured's Name _____

Insured's Birth Date_____ Insured's ID or Social Security Number_____

Insured's Employer _____

Insurance Company_____Group No._____Local No._____

Insurance Co. Address & Phone Number_____

_____

Authorization for Release of Health Information & Signature On File

I authorize Christina Gasper DDS, MS to release to hospital or health care service plans, insurance companies, self-insurers, or their representatives, any and all information and records (including x-rays) about my medical history, or about services rendered or treatment given to me, that is needed to review, investigate or evaluate any claim for benefits. I further authorize Christina Gasper DDS, MS to affix my name to any and all claims or documents as related to any and all health benefits due me through my employment with _____.

If my coverage is under a group master agreement held by my employer, an association, trust fund, union or similar entity, this authorization also permits disclosure to them for purposes of utilization review or financial audit.

I know that I have the right to receive a copy of this authorization if requested.

_____
Name of Patient

_____ _____
Date Signature of Patient, Parent or Guardian

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Health History

PATIENT NAME (Please print): _____

I. CIRCLE APPROPRIATE ANSWER (leave blank if you do not understand question):

1. ☐ Yes ☐ No Are you in pain or discomfort at this time?
2. ☐ Yes ☐ No Do you feel nervous about having dental treatment?
3. ☐ Yes ☐ No Have you had problems with prior dental treatment or have you had a bad dental experience?
4. ☐ Yes ☐ No Is your general health good?
5. ☐ Yes ☐ No Has there been a change in your health within the last year?
6. ☐ Yes ☐ No Have you been hospitalized or had a serious illness in the last three years? If YES, why? _____
7. ☐ Yes ☐ No Are you being treated by a physician now? For what? _____

Date of last medical exam:_____ Date of last dental exam: _____

II. DO YOU HAVE OR HAVE YOU HAD:

8. ☐ Yes ☐ No Allergies to: drugs, medications, latex, foods?
9. ☐ Yes ☐ No Cardiac transplant that developed a heart valve problem?
10. ☐ Yes ☐ No A history of infective endocarditis?
11. ☐ Yes ☐ No An artificial heart valve?
12. ☐ Yes ☐ No Cyanotic congenital heart disease (unrepaired or incompletely repaired)?
13. ☐ Yes ☐ No Congenital heart defect completely repaired with a prosthetic material or device?
14. ☐ Yes ☐ No Repaired congenital heart defect with a residual defect at the site or adjacent to the site of a prosthetic patch or device?
15. ☐ Yes ☐ No Any joint replacement surgery?
16. ☐ Yes ☐ No A joint replacement less than 2 years ago?
17. ☐ Yes ☐ No Previous prosthetic joint infections?
18. ☐ Yes ☐ No Rheumatoid arthritis or systemic lupus erythematosus?
19. ☐ Yes ☐ No Insulin dependent diabetes?
20. ☐ Yes ☐ No HIV infection/AIDS?
21. ☐ Yes ☐ No Drug- or radiation-induced immunosupression?
22. ☐ Yes ☐ No Hemophilia?
23. ☐ Yes ☐ No An implanted coronary artery bare-metal stent? Date placed:_____
24. ☐ Yes ☐ No An implanted coronary artery drug-eluting stent? (DES)? Date placed:_____

III. DO YOU TAKE OR HAVE YOU EVER TAKEN?

25. ☐ Yes ☐ No Drugs for osteoporosis (e.g. Fosamax, Actonel, Boniva)?
26. ☐ Yes ☐ No Chemotherapy IV drugs: Aredia (pamidronate), Bonefos (clodronate), Zometa (zolendronic acid)?
27. ☐ Yes ☐ No Anti-platelet therapy (e.g. Aspirin + Plavix (clopidogrel) or Ticlid (ticlopidine)?
28. ☐ Yes ☐ No The diet pills FEN-PHEN or REDUX?

28a. ☐ Yes ☐ No Since taking the drug, have you been evaluated by a cardiologist and had an echocardiogram?

28b. ☐ Yes ☐ No IF YES, has a cardiologist diagnosed heart damage and recommended antibiotic prophylaxis for dental care?

IV. HAVE YOU EXPERIENCED:

29. ☐ Yes ☐ No Chest pain (angina pectoris)?
30. ☐ Yes ☐ No Swollen ankles?
31. ☐ Yes ☐ No Shortness of breath?
32. ☐ Yes ☐ No Recent weight loss, fever, night sweats?
33. ☐ Yes ☐ No Persistent cough, coughing up blood
34. ☐ Yes ☐ No Bleeding problems, bruising easily, hemophilia?
35. ☐ Yes ☐ No Sinus problems?
36. ☐ Yes ☐ No Difficulty swallowing?
37. ☐ Yes ☐ No Diarrhea, constipation, blood in stools?
38. ☐ Yes ☐ No Frequent vomiting, nausea?
39. ☐ Yes ☐ No Difficulty urinating, blood in urine?
40. ☐ Yes ☐ No Dizziness?
41. ☐ Yes ☐ No Ringing in ears?
42. ☐ Yes ☐ No Headaches?
43. ☐ Yes ☐ No Fainting spells?
44. ☐ Yes ☐ No Blurred vision?
45. ☐ Yes ☐ No Seizures or epilepsy?
46. ☐ Yes ☐ No Excessive thirst?
47. ☐ Yes ☐ No Frequent urination?
48. ☐ Yes ☐ No Dry mouth?
49. ☐ Yes ☐ No Jaundice?
50. ☐ Yes ☐ No Joint pain, stiffness?

Continued on next page

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Health History

PATIENT NAME (Please print): _____

V. DO YOU HAVE OR HAVE YOU HAD:

51.	☐ Yes	☐ No	Heart disease, heart failure?	60.	☐ Yes	☐ No	Tumors, cancer?
52.	☐ Yes	☐ No	Heart surgery	61.	☐ Yes	☐ No	Arthritis, osteoarthritis?
53.	☐ Yes	☐ No	Heart attack, heart defects?	62.	☐ Yes	☐ No	Eye diseases, glaucoma?
54.	☐ Yes	☐ No	Stroke, hardening of arteries?	63.	☐ Yes	☐ No	Skin diseases?
55.	☐ Yes	☐ No	High blood pressure?	64.	☐ Yes	☐ No	Anemia?
56.	☐ Yes	☐ No	Asthma, TB, emphysema, other lung diseases?	65.	☐ Yes	☐ No	VD (syphilis or gonorrhea)?
57.	☐ Yes	☐ No	Hepatitis, other liver disease?	66.	☐ Yes	☐ No	Herpes, cold sores?
58.	☐ Yes	☐ No	Stomach problems, ulcers, colitis?	67.	☐ Yes	☐ No	Kidney, bladder disease?
59.	☐ Yes	☐ No	Family history of diabetes, heart problems, tumors?	68.	☐ Yes	☐ No	Thyroid, adrenal disease?
				69.	☐ Yes	☐ No	Diabetes?

VI. DO YOU HAVE OR HAVE YOU HAD:

70.	☐ Yes	☐ No	Psychiatric care?	75.	☐ Yes	☐ No	Blood transfusions?
71.	☐ Yes	☐ No	Drug addiction?	76.	☐ Yes	☐ No	Surgeries (including cosmetic surgeries)?
72.	☐ Yes	☐ No	Radiation treatments?	77.	☐ Yes	☐ No	Heart pacemaker?
73.	☐ Yes	☐ No	Chemotherapy?	78.	☐ Yes	☐ No	Contact lenses?
74.	☐ Yes	☐ No	Hospitalization?				

VII. DO YOU USE OR DO YOU TAKE:

79.	☐ Yes	☐ No	Recreational drugs?	81.	☐ Yes	☐ No	Tobacco in any form?
80.	☐ Yes	☐ No	Drugs, medications, over-the-counter medicines (including aspirin), natural remedies?	82.	☐ Yes	☐ No	Alcohol?
				83.	☐ Yes	☐ No	Do you take or have you taken cortisone medication (steroids)?

Please list drugs and medications that you are currently taking:

VIII. WOMEN ONLY:

84.	☐ Yes	☐ No	Are you or could you be pregnant or nursing?	85.	☐ Yes	☐ No	Taking birth control pills?

IX. ALL PATIENTS:

86. ☐ Yes ☐ No Do you have or have you had any other diseases or medical problems NOT listed on this form? If so, please explain:

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication.

Patient's signature: _____ **Date:** _____

UPDATE REVIEWS:

Patient's signature: _____ **Date:** _____

Patient's signature: _____ **Date:** _____

Patient's signature: _____ **Date:** _____

Patient's signature: _____ **Date:** _____

Patient's signature: _____ **Date:** _____

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Patient Care Guidelines

Thank you for choosing Dr. Gasper as your periodontal health care provider. Our practice reputation is built upon a commitment to delivering the finest available periodontal treatment to our patients. When we take care of you, assuring your good health through the safest and most comfortable treatment options available is our top priority and focus. As a valued patient in our practice, we ask that you review the following important patient care guidelines.

Office days: Office business days are Monday through Thursday beginning at 8:00 a.m.

Appointment schedule changes: If it becomes necessary for you to reschedule or cancel an appointment, we will do our best to accommodate your changes. To change a reserved appointment, please call us:

- For all non-surgical appointments: call at least two (2) of our business days (Monday-Thursday) in advance of the scheduled appointment.
- For surgical appointments: call at least one (1) week in advance of the scheduled appointment.

Less notice may result in a late-notice appointment change fee.

Our billing practices are designed to be fair to everyone concerned. If late-notice appointment changes can be mitigated, we will do so. Otherwise, late-notice appointment change fees will be applied as follows:

- For any non-surgical appointment: full fee for the appointment.
- For a surgery/treatment appointment with Dr. Gasper: 10% to 15% of the surgical treatment fee.

Payment for services: Please plan to pay for your treatment on the day of your appointment. We accept Visa, MasterCard, American Express, personal checks and cash.

Financial arrangements for surgical treatment: Interest-free options are available for 60 days (in-house) and 6 month (third-party lender) payment plans to cover surgical treatment fees.

Dental insurance: We are always happy to assist our patients in obtaining their available benefits with their third party dental insurance plans. Dental insurance is a contracted benefit between the patient, her/his employer, and the insurance carrier. At no time is the insurance carrier obligated to pay benefits to the periodontal/implant practice. The patient or patient's guardian is responsible for the entire balance of their account regardless of expected or implied insurance benefits. As a courtesy to you, we will process your third party claims for major treatment and instruct your carrier to pay you directly. Should the dental insurance carrier inadvertently send payment to our office, we will return it to the carrier with a request that the check be reissued directly to you. Should the dental insurance carrier require x-rays to support the dental claim and your x-rays are film-based (not digital), your films will be outsourced to a commercial x-ray laboratory for processing. You will be advised of the fee from the laboratory at the time of the request and will be responsible for the cost associated with the duplication.

Finance charges: Balances over 30 days past due are subject to finance charges of 1.5% per month.

Returned checks: A $25.00 charge will apply for checks returned for insufficient funds.

Thank you for your understanding and cooperation with these patient care guidelines.

I have read, understand and agree to the above information:

_____

Signature of patient or responsible party Date