SANTA MARIA PERIODONTICS

dental practice of
MARIA R. SILVERA PORTACIO PhD, DDS, Inc
DIPLOMATE OF THE AMERICAN BOARD OF PERIODONTOLOGY

Welcome: a message from Dr. Silvera

I am looking forward to meeting you personally. Santa Maria Periodontics provides comprehensive periodontal services including treatment of gum disease, cosmetic procedures, and dental implants.

We are committed to ensuring your comfort and successful treatment in a pleasant, state-of-the-art practice. After a thorough review of your needs, goals, and desires, I will discuss with you the diagnoses, treatment options, prognosis, fees, and estimated time required for your treatment.

A little about me: I am a graduate of the Mayo Clinic Advanced Educational Program in Periodontics and also hold a PhD in Immunology from the University of Rochester. After completing all of my education I started practicing in Arizona, then four years later I made my move to California and have been practicing on the Central Coast since 2005. I have been working in periodontics for over ten years. I am excited to announce my becoming a Diplomate of the American Board of Periodontology!

Enclosed are a couple of forms I will need for your first appointment and a patient page from the American Academy of Periodontology titled "Who is a Periodontist?" which describes my area of dental expertise. Please fill out the forms carefully and bring them with you on your consultation visit.

Below is a short checklist of everything you will need for your first appointment, please check off all that apply:

- ☐ Completed registration forms (included)
- ☐ Referral slip from your dentist (if you were referred to our office)
- ☐ X-Rays (you may request a copy from your dentist or have them emailed to us)
- ☐ Dental insurance card or information (including the group number and member ID number)
- ☐ Medication list (if you are taking any medications or vitamins/supplements)
- ☐ Primary physician's contact information (if you are under a doctor's care)

Please feel free to contact our office with any inquiries that you may have. My staff and I are here to support you as a valued patient. We are committed to assisting you in maintaining healthy teeth and gums for a lifetime.

Dr. Maria Silvera

Friendly ♡ Caring ♡ Thorough

620 W. Main Street, Suite A, Santa Maria, CA 93458

phone 805-928-7979 fax 805-928-7955 email silvera@smperiodontics.com web www.healthyteethandgumsinsantamaria.com

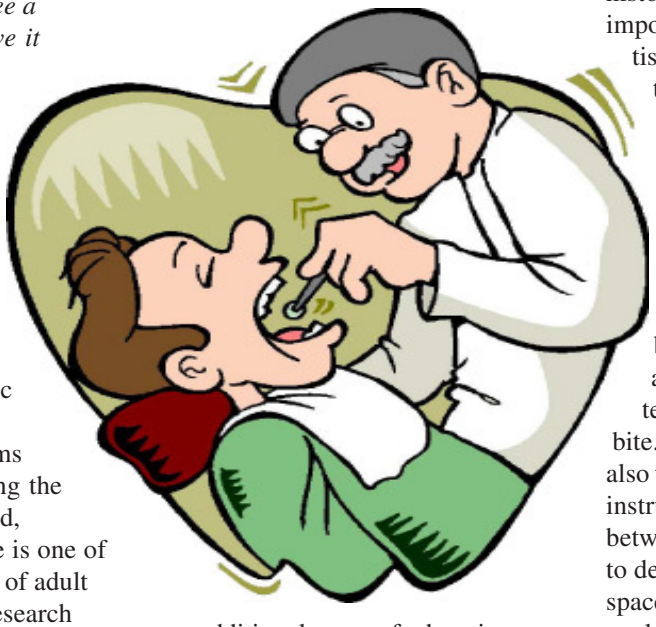
Your Doctor and You

Who is a Periodontist?

Have you been told that you may have periodontal disease and need to see a periodontist? If you have, you probably thought, "*What is periodontal disease and why do I need to see a periodontist to have it treated?*"

The word "periodontal" refers to the gum tissue and bone around the tooth. Periodontal diseases, also known as gum disease, is a chronic bacterial infection that affects the gums and bone supporting the teeth. Left untreated, periodontal disease is one of the primary causes of adult tooth loss. Also, research has found a relationship between periodontal disease and more serious health problems such as heart disease, diabetes, respiratory disease and preterm low birth weight babies.

A periodontist is a dentist who specializes in the prevention, diagnosis and treatment of periodontal disease and in the placement of dental implants. Periodontists receive three additional years of education beyond dental school in this specialty. Periodontists are familiar with the latest techniques for diagnosing and treating periodontal disease and they can also perform cosmetic periodontal procedures to help you achieve the smile you desire.



During your first visit, your periodontist will review your complete medical and dental history with you. It is very important for your periodontist to know if you are taking any medications or are being treated for any condition, as it may affect your periodontal care. Your gums will be examined to see if there is any gum line recession, and your teeth will be checked to see if any are loose and how the teeth fit together when you bite. Your periodontist will also take a small measuring instrument and place it between your teeth and gums to determine the depth of spaces known as periodontal pockets. X-rays may also be taken to observe the health of the bone below your gums. If treatment is needed, a periodontist will discuss a treatment plan with you.☺

For more information visit www.perio.org

When Should I see a Periodontist?

Anytime is a good time to see a periodontist for a periodontal evaluation!

Sometimes the only way to detect periodontal disease is through a periodontal evaluation. If you notice any symptoms, a periodontal evaluation may be especially important for you!

Common symptoms of periodontal disease include:

- Loose or separating teeth.
- Red, swollen or tender gums.
- Gums that bleed easily, such as during brushing and flossing.
- Gums that have pulled away from the teeth.
- Pus between the teeth and gums.
- A change in the way your teeth fit together when you bite.
- Persistent bad breath.

In addition to your periodontal evaluation, when you visit your periodontist, they will conduct a comprehensive risk assessment.

There are many risk factors that may increase your chances of having periodontal disease such as tobacco use, diabetes, and genetics. If you have any of these risk factors or symptoms, you may want to visit a periodontist. To find a periodontist in your area, visit www.perio.org for an online referral.

PATIENT REGISTRATION

First Name: _____ **Last Name:** _____ **Middle Initial:** _____

Patient is: ☐ Policy Holder ☐ Responsible Party **Preferred Name:** _____

Responsible Party (if someone other than the patient)

Name: _____ Last Name: _____ Middle Inital: _____

Address: _____ Second Address: _____

City: _____ State / Zip: _____ _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Age: _____ Social Security: _____ Drivers Lic: _____

☐ Responsible Party is also Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: _____ Second Address: _____

City: _____ State / Zip: _____ _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: _____ Age: _____ Social Security: _____ Drivers Lic: _____

E-mail: _____ ☐ I would like to receive correspondences via E-mail

Section 2

Employment Status ☐ Full Time ☐ Part Time ☐ Retired

Student Status ☐ Full Time ☐ Part Time

Medicaid ID: _____ Pref. Dentist: _____

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg.: _____

Section 3

Referred By: _____

Referring Dentist: _____

Emergency Contact : _____

Emergency Contact Phone #: _____

Are you Diabetic?: _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Social Security: _____ Insured Birth Date: _____

Employer: _____ Insurance Company: _____

Address: _____ Address: _____

_____ _____

City, State, Zip: _____ City, State, Zip: _____

Remaining Benefits: _____.00 Remaining Deductible: _____.00

Seconday Insurance Information

Name of Insured: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Social Security: _____ Insured Birth Date: _____

Employer: _____ Insurance Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City, State, Zip: _____ City, State, Zip: _____

Remaining Benefits: _____.00 Remaining Deductible: _____.00

MEDICAL HISTORY

Patient Name _____ Birth Date_____

Although dental personnel primarly treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ○ Yes ○ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ○ Yes ○ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ○ Yes ○ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ○ Yes ○ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ○ Yes ○ No
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ○ Yes ○ No
Are you on a special diet? ○ Yes ○ No
Do you use tobacco? ○ Yes ○ No
Do you use controlled substances? ○ Yes ○ No

Women: are you
Pregnant/Trying to get pregnant ○ Yes ○ No Taking oral contraceptives? ○ Yes ○ No Nursing? ○ Yes ○ No

Are you allergic to any of the following?
○ Aspirin ○ Penicillin ○ Codeine ○ Acrylic ○ Metal ○ Latex ○ Local Anesthetics ○ Sulfa drugs
○ Other If yes, please explain: _____

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

AIDS/HIV Positive ○ Yes ○ No	Cortisone Medicine ○ Yes ○ No	Hemophilia ○ Yes ○ No	Radiation Treatments ○ Yes ○ No
Alzheimer's Disease ○ Yes ○ No	Diabetes ○ Yes ○ No	Hepatitis A ○ Yes ○ No	Recent Weight Loss ○ Yes ○ No
Anaphylaxis ○ Yes ○ No	Drug Addiction ○ Yes ○ No	Hepatitis B or C ○ Yes ○ No	Renal Dialysis ○ Yes ○ No
Anemia ○ Yes ○ No	Easily Winded ○ Yes ○ No	Herpes ○ Yes ○ No	Rheumatic Fever ○ Yes ○ No
Angina ○ Yes ○ No	Emphysema ○ Yes ○ No	High Blood Pressure ○ Yes ○ No	Rheumatism ○ Yes ○ No
Arthritis/Gout ○ Yes ○ No	Epilepsy or Seizures ○ Yes ○ No	High Cholesterol ○ Yes ○ No	Scarlet Fever ○ Yes ○ No
Artificial Heart Valve ○ Yes ○ No	Excessive Bleeding ○ Yes ○ No	Hives or Rash ○ Yes ○ No	Shingles ○ Yes ○ No
Artifical Joint ○ Yes ○ No	Excessive Thirst ○ Yes ○ No	Hypoglycemia ○ Yes ○ No	Sickle Cell Disease ○ Yes ○ No
Asthma ○ Yes ○ No	Fainting Spells/Dizziness ○ Yes ○ No	Irregular Heartbeat ○ Yes ○ No	Sinus Trouble ○ Yes ○ No
Blood Disease ○ Yes ○ No	Frequent Cough ○ Yes ○ No	Kidney Problems ○ Yes ○ No	Spina Bifida ○ Yes ○ No
Blood Transfusion ○ Yes ○ No	Frequent Diarrhea ○ Yes ○ No	Leukemia ○ Yes ○ No	Stomach/Intestinal Disease ○ Yes ○ No
Breathing Problem ○ Yes ○ No	Frequent Headaches ○ Yes ○ No	Liver Disease ○ Yes ○ No	Stroke ○ Yes ○ No
Bruise Easily ○ Yes ○ No	Genital Herpes ○ Yes ○ No	Low Blood Pressure ○ Yes ○ No	Swelling of Limbs ○ Yes ○ No
Cancer ○ Yes ○ No	Glaucoma ○ Yes ○ No	Lung Disease ○ Yes ○ No	Thyroid Disease ○ Yes ○ No
Chemotheraphy ○ Yes ○ No	Hay Fever ○ Yes ○ No	Mitral Vavle Prolapse ○ Yes ○ No	Tonsilitis ○ Yes ○ No
Chest Pains ○ Yes ○ No	Heart Attack/Failure ○ Yes ○ No	Osteoperosis ○ Yes ○ No	Tuberculosis ○ Yes ○ No
Cold Sores/Fever Blisters ○ Yes ○ No	Heart Murmur ○ Yes ○ No	Pain in Jaw Joints ○ Yes ○ No	Tumros or Growths ○ Yes ○ No
Congenital Heart Disorder ○ Yes ○ No	Heart Pacemaker ○ Yes ○ No	Parathyroid Disease ○ Yes ○ No	Ulcers ○ Yes ○ No
Convulsions ○ Yes ○ No	Heart Trouble/Disease ○ Yes ○ No	Psychiatric Care ○ Yes ○ No	Venereal Disease ○ Yes ○ No
			Yellow Jaundice ○ Yes ○ No

Have you ever had a serious illness not listed above? ○ Yes ○ No If yes, please explain: _____

Comments: _____

To the best of my knowledge, the questions on this form have been accuratley answered, I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in my medical status.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN _____ DATE _____

INITIAL QUESTIONS

Were you referred by your Dentist? ○ **YES** ○ **NO** What is your Dentist's name: _____

Let us know how you heard about Dr. Silvera? _____

Please list all sources: _____

If you found us online please let us know which site or which key words you used: _____

Do you know why you are here today? _____

Do you have any other dental concerns? _____

How tall are you? _____

How much do you weigh? _____

Frequency of professional dental cleanings: _____

Date of last professional cleaning: _____

ALCOHOL / TOBACCO

Do you drink alcohol? ○ **YES** ○ **NO**

Do you smoke or have you ever smoked? ○ **YES** ○ **NO**

How long have you been smoking? _____

How many cigarettes do you smoke a day? _____

If you quit, how long has it been? _____

How long did you smoke before quitting? _____

How many cigarettes did you smoke a day? _____

DIABETES ○ YES ○ NO

Which type? ○ **TYPE 1** ○ **TYPE 2**

Do you check your glucose level at home? ○ **YES** ○ **NO** If yes, how often? _____

Date of last Hemoglobin A1C? _____ What was the value? _____

Name of the Medical Doctor who checks your Hemoglobin A1C: _____

Medical Doctor's Phone: _____

ASTHMA ○ YES ○ NO

If allergic type, what are you allergic to? _____

What triggers the asthmatic attack? _____

What drug(s) do you take to control your asthma? _____

Do you take inhaled corticosteroids? ○ **YES** ○ **NO** If yes, how often? _____

Have you ever had an asthma attack did not stop? ○ **YES** ○ **NO**

Have you ever been hospitalized for asthma? ○ **YES** ○ **NO**

SEIZURES ○ YES ○ NO

If yes, please circle the type of seizure(s) from the list below:

Grand - mal seizure (Tonic - clonic seizure)
Petit - mal seizure (absence seizure)
Atypical absence seizure
Myoclonic seizure
Atonic or akinetic seizure
Simple partial seizure
Complex partial seizure (people with head injuries, brain infection, stroke, or brain tumor)

What do you take to control your seizures? _____

How may seizures a week, a month, or a year do you experience? _____

What is your aura? _____ Is it visual like a rainbow, sound or smell? ○ **YES** ○ **NO**

Have you ever been hospitalized because of a seizure? ○ **YES** ○ **NO**

Have you ever had a seizure which did not stop? ○ **YES** ○ **NO**

HOME CARE, ORAL HABITS, AND TREATMENT HISTORY

HOME CARE

How Often Do You Brush? _____ Brand of Toothpaste: _____

How Often Do You Floss? _____ Brand of Mouthwash: _____

Other: _____

ORAL HABITS

Grind Teeth:	Present	Past	Never
Bite Cheek:	Present	Past	Never
Tongue Thrust:	Present	Past	Never
Mouth Breather:	Present	Past	Never
Bulimia/Anorexia:	Present	Past	Never
Cigar/Cigarette:	Present	Past	Never
Pipe:	Present	Past	Never
Bite Nails:	Present	Past	Never
Smokeless Tabacco:	Present	Past	Never
Thumb/Finger:	Present	Past	Never
Toothpick/Stimulator:	Present	Past	Never
Chewing Gum:	Present	Past	Never
Candy:	Present	Past	Never
Soft Drinks:	Present	Past	Never

Other: _____

TREATMENT HISTORY

Are Your Teeth Sensitive To:

Hot or Cold:	Present	Past	Never
Biting/Chewing:	Present	Past	Never
Sweets:	Present	Past	Never

Have You Ever Had:

Orthodontic Treatment:	Present	Past	Never
A Bite Plate or Guard:	Present	Past	Never
Periodontic Treatment	Present	Past	Never
Oral Surgery:	Present	Past	Never
Serious Injury to Mouth or Head:	Present	Past	Never