ALAN M. TIMKO, DMD
Diplomate of the American Board of Periodontology

DATE: _____

PATIENT NAME: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
EMAIL: _____

CELL PHONE NO. _____
OTHER PHONE NO. _____
SOC. SEC. NO. _____
BIRTHDATE: _____ AGE: _____

OCCUPATION: _____
EMPLOYER: _____
WORK ADDRESS: _____

MARITAL STATUS: _____
SPOUSE'S NAME: _____
SPOUSE'S PHONE NO. _____

---

NEAREST RELATIVE NOT LIVING WITH YOU WHO WE MAY CONTACT IN CASE OF EMERGENCY?
NAME: _____
ADDRESS: _____
PHONE: _____

DENTAL INS CO: _____
GROUP NO. _____
MEMBER ID. _____
SUBSCRIBER NAME: _____
SUBSCRIBER DATE OF BIRTH: _____
SUBSCRIBER SOC. SEC. NO. _____
SUBSCRIBER EMPLOYER: _____

MEDICAL INS CO: _____
GROUP NO. _____
MEMBER ID. _____
SUBSCRIBER NAME: _____
SUBSCRIBER DATE OF BIRTH: _____
SUBSCRIBER SOC. SEC. NO. _____
SUBSCRIBER EMPLOYER: _____

**I HEREBY AUTHORIZE PAYMENT OF THE DENTAL BENEFITS OTHERWISE PAYABLE TO ME DIRECTLY TO DR. ALAN TIMKO**

SIGNATURE: _____

YOUR DENTIST'S NAME:
_____
ADDRESS: _____
_____
PHONE NO. _____

YOUR PHYSICIAN'S NAME:
_____
ADDRESS: _____
_____
PHONE NO. _____

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?
NAME: _____
ADDRESS: _____
_____

WHO WILL BE FINANCIALLY RESPONSIBLE FOR THIS BILL? _____

**I UNDERSTAND THAT I AM ULTIMATELY RESPONSIBLE FOR ANY AND ALL FEES INCURRED AND FOR THE COSE OF RECOVERY.**

SIGNATURE:
_____

ALAN M. TIMKO, DMD
Diplomate of the American Board of Periodontology

HEALTH QUESTIONNAIRE

How would you describe your present state of health? [ ] Excellent [ ] Good [ ] Fair [ ] Poor

Have you ever been hospitalized? [ ] Yes [ ] No

Have you been under a Doctor's care during the pat two years? [ ] Yes [ ] No

Do you take any kind of drugs, medication (prescription or non-prescription), herbs, vitamins, etc.? [ ] Yes [ ] No

Do you have any allergies? [ ] Yes [ ] No

Have you had excessive bleeding that required special treatment? [ ] Yes [ ] No

Do you have any of the following?
[ ] persistent cough [ ] fatigue [ ] loss of appetite
[ ] unexplained weight loss [ ] diarrhea [ ] yeast infections
[ ] swollen lymph glands [ ] fever [ ] night sweats

Is there a history of diabetes in your family? [ ] Yes [ ] No

Are you required to restrict your work or activity in any way? [ ] Yes [ ] No

Are you on a special or restricted diet of any kind? [ ] Yes [ ] No

Have you ever had a problem with drug or alcohol abuse? [ ] Yes [ ] No

Have you ever been refused as a blood donor? [ ] Yes [ ] No

Check any of the following you may have had:

| | | | |
|---|---|---|---|
| [ ] Heart trouble | [ ] Mitral valve problems | [ ] Aids | [ ] Oral Candidasis |
| [ ] Congenital Heart lesions | [ ] Glaucoma | [ ] Tuberculosis | [ ] Joint replacement prosthesis |
| [ ] Heart Murmur | [ ] Hepatitis | [ ] Asthma | [ ] Hairy leukoplakia |
| [ ] Heart Surgery | [ ] Diabetes | [ ] Cancer | [ ] Kaposi's sarcoma |
| [ ] Rheumatic fever | [ ] Jaundice | [ ] Epilepsy | [ ] Cold sores |
| [ ] Cardiac pacemaker | [ ] Psychiatric care | [ ] Arthritis | [ ] Sinus trouble |
| [ ] Heart valve Prosthesis | [ ] Kidney disease | [ ] Stroke | [ ] Venereal disease |
| [ ] High/low blood pressure | [ ] Persistent cough | [ ] Eating disorder | [ ] Recurrent mouth ulcers |
| [ ] Thyroid problems | [ ] Traume/broken bones | [ ] Eye trouble | [ ] Osteoporosis |

Have you ever had a blood transfusion? [ ] Yes [ ] No
Have you ever taken the appetite suppressants fen-phen? {fenfluramine (phondimen), or desfenfluramine (redux)}? [ ] Yes [ ] No
Has your Physician/Dentist ever told you that you should take antibiotics before EVERY dental treatment? [ ] Yes [ ] No
Have you traveled internationally in the last 10 days? [ ] Yes [ ] No
Have you come in contact with a SARS patient in the past 10 days? [ ] Yes [ ] No
Do you currently have a fever? [ ] Yes [ ] No
Do you have any disease or condition not listed above that you feel we should know about? [ ] Yes [ ] No
If so, explain_____
_____

PATIENT SIGNATURE: _____ DATE: _____

**Alan M Timko, D.M.D.**
**Diplomate of the American Board of Periodontology**

Reconstructive Periodontal and Implant Surgery
Periodontal Regenerative Surgery, Pre-Prosthetic Surgery, Periodontal Plastic Surgery
Comprehensive Post-Operative Periodontal Supportive Therapy

# CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION, HEALTH INSURANCE AND ACCOUNTABILITY ACT (HIPAA)

I hereby give my consent for Alan M Timko, DMD to use and disclose protected health information about me to carry out treatment, payment and health care operations. I have the right to review the Notice of Privacy Practices prior to signing this consent. Dr Timko reserves the right to revise his Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Alan M Timko, DMD, 9401 McKnight Road, Suite 301-A, Pittsburgh, PA 15237. With this consent, Dr Timko and staff may call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying our treatment, payment or other health care operations (TPO), such as appointments, reminders, insurance items, and any calls pertaining to my clinical care, including laboratory test results, among others. With this consent, Dr Timko and staff may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment card reminders and patient statements. With this consent, Dr Timko and staff may email to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements. I have the right to request that Dr Timko restrict how they use or disclose my protected health information (PHI) to carry our TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to all Dr Timko and staff to use and disclose my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Dr Timko may decline to provide treatment to me.

_____ _____

**Patient's name** **Date**

_____

**Signature of Patient or Legal Guardian**