# Nuvia New Patient Welcome Packet

Patient Name: **Paulette Greene**

Date: **05-Nov-2025**

Birthdate: **09-Jul-1959** Age: **66** Sex: **Female**

Marital Status: **Married**

Home Address: **2147 Vacation Ln**

City: **Pocono summit** State: **Pa** Zip: **18346**

Home Phone: **(570) 909-3435** Cell:

Email Address: **Paulettegreene6853@gmail.com**

Employer: Employer Phone:

Emergency Contact **Kelvin greene** Phone Number **(570) 677-6312**

Are you OK with receiving text messages? **No**

Reason for Today's Visit:

**Consultation**

Have you had a consultation for implants before?

**No**

Due to HIPAA privacy laws, if you (the patient) are 18 years of age or older, our office cannot discuss any details regarding your office visits or billing account information with anyone unless you choose to authorize a person(s) in the space provided authorize **Nuvia Dental Implant Center to disclose my health information to the following person(s):**

**N/a**

NUVIA
DENTAL IMPLANT CENTER

# Nuvia Dental Implant Center Policies & Procedures:

**HIPAA Policy**

I acknowledge that, in an effort to improve every patient's experience, part or all of the Screening may be recorded in both audio and video formats to be used solely by the Organization's personnel for quality assurance purposes and for the Organization's partnering doctor(s) to determine my eligibility for Treatment. I hereby: (a) consent to having my Screening recorded as part of the Organization's quality assurance program; (b) acknowledge that such audio and/or video recordings may contain Protected Health Information governed by the Health Insurance Portability and Accountability Act of 1996 and all other related privacy laws, rules, and regulations; and (c) consent and agree to the Organization's use and disclosure of such recordings for quality assurance purposes or pursuant to any order of a court of competent jurisdiction.

This agreement supersedes all prior agreements signed, including any and all medication or mediation/arbitration agreements. I acknowledge that I have received a copy of Nuvia Dental Implant Center's Privacy Policy (HIPAA Agreement). I hereby agree and abide by the condition outlined herein.

I understand that, under the Health Insurance Portability Act of 1996 (HIPAA) I have certain rights to privacy regarding my protected health information. I understand that this information will be used to:

*Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
*Obtain payment from 3rd party lenders.
*Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you and of your office Privacy Policies containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Office Privacy Policies prior to signing consent. I understand that this organization has the right to change its Office Privacy Policies from time to time and that I may contact this organization at any time at the address listed on the copy of Office Privacy Policies and I may contact them at the address listed.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you don't agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that Nuvia Dental Implant Center has taken action relying on this consent.

05-Nov-2025

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# Medical Intake Form

**Patient Name** **Paulette Greene**

**D.O.B:** **09-Jul-1959** **Pt Height:** **5'3"** **Pt Weight:** **170**

**General Practitioner (PCP):** **Geisinger health**

**Last Visit:** **07/2025**

**Please list any other doctors that you see or have seen in the past.**

**Primary**

**Please list your current medical problems.**

**Slight diabetes**

**Please list your past surgeries.**

**N/a**

**Please list all of your current medications.**

**Losartin**

**Please list any allergies you have.**

**None**

**No** **Have you ever seen a Pulmonologist (lung specialist)?**

**No** **Have you ever been diagnosed with COPD?**

**No** **Have you ever been diagnosed with asthma ?**

**No** **Do you use an inhaler (albuterol)?**

If so, how often?

**Yes** **Do you have Cystic Fibrosis?**

**No** **Do you require the use of oxygen at home?**

**No** **Have you ever had a pulmonary embolism?**

**If yes, when?**

**No** **Have you ever seen a Cardiologist?**

**If yes, when was your last visit?**

**What was the reason for your visit?**

**Yes** **Do you have or are you being treated for high blood pressure?**

**No** **Do you have heart failure?**

**No** **Do you have A-fib (atrial fibrillation)?**

**No** **Do you have any kind of heart arrhythmia (irregular beat)?**

**No** **Have you ever had a heart attack?**

**If Yes, when?**

**No** **Have you ever had a blood clot or stroke?**

**No** **Do you have any heart valve problems?**

**No** **Do you have a pacemaker?**

**No** **Do you have any liver disease?**

**No** **Do you have any kidney disease?**

**No** **Are you currently on dialysis for kidney disease?**

**Yes** **Do you consume alcohol?**

**If yes, how often?**

**Yes** **Do you smoke?**

**If yes, how often?** **Daily**

**No** **Do you Vape?**

**If yes, how often?**

**No** **Do you use marijuana?**

**If yes, how often?**

**No** **Do you currently use illicit drugs (i.e. meth, cocaine, heroin, opioids)?**

**No** **Do you have a past history of using illicit drugs (i.e. meth, cocaine, heroin, opioids)?**

**No** **Are you currently pregnant?**

**No** **Have you ever been told that you have a difficult airway (during surgery/anesthesia)?**

**No** **Do you get chest pain while exercising or walking up a flight of stairs?**

**No** **Are you on blood thinners (i.e. eliquis, warfarin, plavix)?**

**No** **Do you have sleep apnea requiring any devices or oxygen at night?**

**No**

**Have you ever had radiation treatment to your jaws or head or neck region for cancer treatment or pathology (Not counting X-Rays or CT Scans)?**

**No**

**Do you take or have you ever taken antiresorptive medication to protect your bones either from osteoporosis or certain forms of cancer (i.e. fosamax, boniva)?**

**No** **Do you have an autoimmune disease (i.e. rheumatoid arthritis, lupus)?**

**Yes** **Do you have diabetes?**

**If yes, do you know the date and value of your last HbA1c? 08/2025**

**No** **Are you taking Ozempic or any type of semaglutide for weight loss or diabetic control?**

**If yes, please list :**

**No** **Do you have or have you ever been infected with Hepatitis A, B, or C virus?**

**If yes, type:**

**No** **Do you have or have you ever been infected with Human Immunodeficiency Virus (HIV)**

**Yes** **Do you have a hiatal hernia or severe acid reflux (GERD)?**

**No** **Do you have a personal or family history of Malignant Hyperthermia?**

**No** **Have you ever had an adverse reaction to anesthesia?**

**If yes, please explain:**

**To The best of my knowledge, all the preceding answers are true and correct. If I ever have any change in my health, abnormal laboratory test, or if my medications change, I will inform the doctor at my next appointment.**

**Patient Signature:**

**Date:**05-Nov-2025

**Office Use Only:**

**Provider Signature: _____**

**Date Medical Intake Form Reviewed: _____**