



Nuvia New Patient Welcome Packet

Patient Name: Catherine La Grone

Date: 06-Nov-2025

Birthdate: 13-Apr-1953

Age: 72

Sex: Female

Marital Status: Single

Home Address: 8327 Lone Bridge Lane

City: Humble

State: Texas

Zip: 77338

Home Phone: (832) 683-1092

Cell:

Email Address: LaGroneJairus@yahoo.com

Employer:

Employer Phone:

Emergency Contact Jonah LaGrone Phone Number (832) 894-4991

Are you OK with receiving text messages? Yes

Reason for Today's Visit:

First appt.

Have you had a consultation for implants before?

Yes

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):**

Jairus and Jonah LaGrone, Shirley LaGrone-Tryon



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.



06-Nov-2025



Medical Intake Form

Patient Name Catherine La Grone

D.O.B: 13-Apr-1953 Pt Height: 5'11" Pt Weight: 174

General Practitioner (PCP): Dr. Kelly Suddlelight

Last Visit: Yesterday

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

Cardiologist Dr. Shum

Pulmonologist Dr. Belljani

Please list your current medical problems.

heart failure

One lung

High blood pressure

COPD

Heart arrhythmia

Please list your past surgeries.

Knee replacements

Lung removal 2019

Please list all of your current medications.

See list

Please list any allergies you have.

Penicillin.

Yes Have you ever seen a Pulmonologist (lung specialist)?

Yes Have you ever been diagnosed with COPD?

No Have you ever been diagnosed with asthma ?

Yes Do you use an inhaler (albuterol)?

If so, how often? **Daily**

No Do you have Cystic Fibrosis?

Yes Do you require the use of oxygen at home?

No Have you ever had a pulmonary embolism?

If yes, when?

Yes Have you ever seen a Cardiologist?

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

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

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

No Do you have heart failure?

Yes Do you have A-fib (atrial fibrillation)?

Yes 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?

No Do you consume alcohol?

If yes, how often?

No Do you smoke?

If yes, how often?

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?

Yes Are you on blood thinners (i.e. eliquis, warfarin, plavix)?

Yes 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)?

No Do you have diabetes?

If yes, do you know the date and value of your last HbA1c?

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:

A handwritten signature in black ink, reading "Catherine Ellen LaBonte". The signature is written in a cursive, flowing style.

Date:06-Nov-2025

Office Use Only:

Provider Signature: _____

Date Medical Intake Form Reviewed: _____