
We are pleased to welcome you to our office. Please take a few minutes to fill out this form completely. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Name: _____ Preferred Name: _____

Patient Birth Date: _____ Sex: M ☐ F ☐ Email: _____

Patient Status: Married ☐ Single ☐ Dependent ☐ Other ☐

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Employer: _____ Occupation: _____

Whom may we thank for referring you to our office? _____

General Dentist (if different from above): _____

## Dental Insurance Information

Patient SSN: _____ Subscriber's SSN or Member ID: _____

| | **Primary** | **Secondary** |
|---|---|---|
| Person Carrying Insurance: | _____ | _____ |
| Dental Insurance Co: | _____ | _____ |
| Group Number: | _____ | _____ |
| Date of Birth (Subscriber): | _____ | _____ |
| Employer (Subscriber): | _____ | _____ |

Authorization

I authorize my insurance company to pay the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorized the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges not paid by my insurance company.

Signature: _____ Date: _____

# Medical History

Patient's Name_____ Date of birth_____ Date: _____

***An accurate and current medical and dental history is necessary to provide you with the safest and most appropriate treatment. Thank you for taking the time to completely answer this questionnaire.***

**GENERAL INFORMATION** Sex: ☐M ☐F Height: _____ Weight: _____lbs
Are you now under the care of a physician? ☐Yes ☐No Last physical Checkup: _____
Have you ever had any serious illness, hospitalization, or surgery? ☐Yes ☐No
Describe: _____
**PREFFERED PHARMACY:** _____
**MEDICATIONS:** (list all medications you are taking including supplements **OR** provide us with a list)

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

**DRUG ALLERGIES:** _____ _____ _____ _____ _____

**DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?**

1. Artificial Joints ☐Yes ☐No
   a. If yes, Location:_____Date:_____
2. Immunosuppressed by drug or disease ☐Yes ☐No
3. Do you routinely pre-medicate with antibiotics before dental treatment ☐Yes ☐No
   Reason: _____
4. Heart Disease
   a. Cardiac Transplant ☐Yes ☐No
   b. High Blood Pressure ☐Yes ☐No
   c. Myocardial Infarction, Heart Attack ☐Yes ☐No
   d. Pacemaker, Heart Surgery ☐Yes ☐No
   e. Stroke ☐Yes ☐No
5. Blood Disorders
   a. Anemia, Bleeding Disorder ☐Yes ☐No
   b. Clotting Disorder ☐Yes ☐No
   c. Blood Transfusion ☐Yes ☐No
6. Diabetes ☐Yes ☐No
   a. Date Diagnosed:_____ Last HbA1c:_____
7. Kidney Disease ☐Yes ☐No
8. Cancer (Type _____) ☐Yes ☐No
9. Chemotherapy ☐, Radiation Treatment ☐ ☐Yes ☐No
10. Arthritis ☐Yes ☐No
11. Seizures, Epilepsy, Fainting ☐Yes ☐No
12. Sinus Problems ☐Yes ☐No
13. PTSD ☐, Depression ☐, Severe anxiety ☐ ☐Yes ☐No
14. Glaucoma ☐ / Loss of Sight ☐ ☐Yes ☐No
15. Hearing Loss ☐Yes ☐No
16. Osteoporosis/Osteopenia ☐Yes ☐No
    a. Have you ever taken oral bisphosphonates or IV bisphosphonate medications? ☐Yes ☐N
    b. How long in treatment? _____
17. Thyroid Disease (Hypo ☐, Hyper ☐) ☐Yes ☐No
18. Gastric Ulcers ☐Yes ☐No
19. Hepatitis, Liver Disease, Jaundice ☐Yes ☐No
20. Blood borne Pathogens: Venereal Disease ☐, Syphilis ☐, Gonorrhea ☐, Herpes ☐, HIV+☐ ☐Yes ☐No
21. Sleep Apnea/CPAP ☐Yes ☐No
22. Asthma, Emphysema, Bronchitis ☐Yes ☐No
23. Tuberculosis ☐Yes ☐No
24. Alcohol ☐ or Drug Use ☐ ☐Yes ☐No
25. Cigarette, Snuff, Vape ☐Yes ☐No
    a. Duration: _____ Quantity:_____Quit Date:_____
26. Regular Steroid Use ☐Yes ☐No
27. Anticoagulants ☐Yes ☐No
    a. Warfarin ☐
    b. Xarelto ☐
    c. Aspirin ☐
    d. Plavix (Clopidogrel) ☐
    e. Eliquis ☐
    f. Pradaxa ☐
    g. Other ☐

Women

1. Regular Menstrual Cycle ☐Yes ☐No
2. Are You Pregnant or is there any chance you could be pregnant ☐Yes ☐No
3. Are You Taking Birth Control Medication ☐Yes ☐No

**It is important that you understand that antibiotics and some other medications may interfere with the effectiveness of oral contraceptives. You may need to use an additional form of birth control for one cycle of birth control pills after a course of antibiotics or other medication is completed. Please consult with your physician.**

# Dental History

Your primary reason for making this appointment:

Who is you regular dentist? _____

When did you last have any dental work done? _____ What was done? _____

When was your last dental cleaning? _____ How long before that? _____

How often do you brush your teeth? _____ Floss? _____

Are you using any other dental cleaning aids? If so, what? _____

- Are you experiencing any pain in your mouth ..... ☐Yes ☐No
- Are your teeth sensitive ..... ☐Yes ☐No
- Are your teeth loose ..... ☐Yes ☐No
- Do you have an unpleasant taste or odor in your mouth ..... ☐Yes ☐No
- Do your gums bleed ..... ☐Yes ☐No
- Has periodontal disease been found in your mouth before ..... ☐Yes ☐No
- Have you ever had periodontal treatment ..... ☐Yes ☐No
    - When and what type: _____
- Do you grind or clench your teeth ..... ☐Yes ☐No
- Have you noticed increasing spaces between your teeth ..... ☐Yes ☐No
- Are your gums receding ..... ☐Yes ☐No
- Are you dissatisfied with the appearance of your teeth ..... ☐Yes ☐No
- Have you ever had orthodontic treatment (Braces) ..... ☐Yes ☐No
- Are you missing teeth that have not been replaced? ..... ☐Yes ☐No
    - Reason for lost teeth: ☐Cavities ☐Gum Disease ☐Trauma
- Are you seeing a doctor for dental implants ..... ☐Yes ☐No
- Do you wear full or partial dentures ..... ☐Yes ☐No
- Are you interested in replacing your missing teeth with dental implants ..... ☐Yes ☐No
- If dissatisfied, why are you dissatisfied with your present appliances:

☐ The Inconvenience ☐ The Appearance ☐ Inability to Chew ☐ Painful ☐ Other _____

## Treatment Authorization and Consent

I consent to examination and necessary or desirable care of the registered patient, for the diagnosis of dental disease, deformity, or treatment, or dental emergency. The procedures may include radiographs, models, photographs, and intra-oral examination. In case of a dental emergency, I consent to emergency treatment as deemed necessary by the doctor. Any non-emergency procedures will be explained in advance. I have read and completed this questionnaire to the best of my knowledge and agree to the above policy.

_____ _____

Patient, Parent, or Legal Guardian Date Periodontist (Reviewed)

# Financial Policy

1. We provide a high quality professional service at a reasonable fee. Payment is expected at the time of service.

2. Payment may be made in the following ways: **Cash, Check, or Credit Card.**

3. 6 Month Payment Plan Option: Care Credit. Care credit is a third party company that allows you to spread your payment over a 6 month period. You must apply for this service online at www.carecredit.com.

4. DISCOUNTS: We do not offer discounts. **This allows our practice to keep our fees as low as possible for everyone.**

5. We know that dental insurance can be confusing. As a courtesy we will file your insurance claim for you. If you desire, we will also do our very best to calculate your "ESTIMATED" out-of-pocket cost prior to treatment. This is based on the information provided from your insurance company on the day we process your estimate. Your insurance company and this office **Do Not Guarantee** these estimates. You are ultimately responsible for charges that exceed your insurance benefits. You will be billed for the difference in such cases.

6. Arrangements must be made on all past due balances prior to seeing a provider.

7. All unpaid balances on the account are subject to a $20.00 per month late fee. All collection costs will be paid for by the patient.

8. Cancellations and Missed Appointment: If you need to cancel or reschedule an appointment please give our office as much notice as possible. You understand that a $50 to $100 fee may be applied for appointment cancelled without 24 hour notice.

I understand and agree to the above Financial Policy.

**Signed:** _____ **Date:** _____

**ACKNOWLEDGEMENT OF PRIVACY RIGHTS**

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance & Accountability Act of 1996 (HIPPA). I understand that this information can and will be used to:

1. Provide and coordinate my treatment among a number of health care providers who may be involved in the treatment directly or indirectly.
2. Obtain payment from third-party payers for my health care services.
3. Conduct normal health care operations such as quality assessment and improvement activities.

I have been informed of my dental provider's Notice of Privacy Practices. I understand that my dental provider has the right to change the Notice of Privacy Practices, and I my request to obtain a current copy.

I may request in writing that this office restrict how my private information is used or disclosed to carry out treatment, payment, or health care operation. I understand that the office is not required to agree to my requested restrictions, but if the office does agree then it is bound to abide by such restrictions.

Signature:_____Date:_____

Relationship to the patient (if signed by a representative of patient)_____

## FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- o Individual refused to sign
- o Communications barriers prohibited obtaining the acknowledgement
- o An emergency situation prevented us from obtaining acknowledgement
- o Other (please specify)_____