Welcome

Thank you for selecting our periodontal healthcare team! We will strive to provide you with the best possible periodontal care. To help us meet all your periodontal needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us- we will be happy to help.

PATIENT INFORMATION (*CONFIDENTIAL*)

Name _____ Birthdate _____ Home phone _____

Address _____ City _____ State _____ Zip _____

Check appropriate box: ❑ Minor ❑ Ms. ❑ Mrs. ❑ Mr. ❑ Dr. ❑ Rev.

Patient's or Parents Employer _____ Work phone _____

Business Address _____ City _____ State _____ Zip _____

Spouse or Parent's Employer _____ Work phone _____

Referring Dentist _____ Physician _____

Person to Contact in case of emergency _____ Phone _____

Patient's Occupation _____ Patient's Social Security # _____

RESPONSIBLE PARTY

Name of person responsible for this account _____ Relationship _____

Address _____ Home phone _____

Employer _____ Work phone _____

INSURANCE INFORMATION

Name of Insured _____ Relationship _____

Birthdate _____ Social security # _____

Name of Employer _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Union or Local # _____

Ins. Co. Address _____ City _____ State _____ Zip _____

Do you have any additional insurance? ❑ Yes ❑ No If yes, complete the following:

Name of Insured _____ Relationship _____

Birthdate _____ Social security# _____

Name of Employer _____ Work Phone _____

Address of Employer _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Union or local# _____

Ins. Co. Address _____ City _____ State _____ Zip _____

How Much is your Deductible? _____ How much have you used? _____ Max, Annual Benefit _____

Over Please

MEDS:

MEDICAL HISTORY

MEDICAL HISTORY — Circle One

Has there been any recent change in your health?..... Yes No

Have you had a physical exam recently?..... Yes No

Are you receiving any treatment by any doctor now?..... Yes No

Have you had a serious illness or operation?..... Yes No

Have you had a tumor or cancer?..... Yes No

Have you had radiation treatment?..... Yes No

Are you taking any medicines now?..... Yes No

Are you allergic to any medicine?..... Yes No

Do you have hay fever or sinus problems?..... Yes No

Are you on a special diet?..... Yes No

Do you suffer from frequent headaches?..... Yes No

Do you have spells of dizziness or fainting?..... Yes No

Do you have any artificial joints or valves?..... Yes No

Do you have any diseases carried in the blood?..... Yes No

Have you been treated for glaucoma?..... Yes No

Do you have arthritis or rheumatism?..... Yes No

Do you smoke?..... Yes No

How many packs/day? _____

CARDIOVASCULAR

Has a physician ever said you had heart trouble?..... Yes No

Have you had rheumatic fever or heart murmur?..... Yes No

Have you ever had a heart attack?..... Yes No

Do you have high or low blood pressure?..... Yes No

Do you get out of breath easily?..... Yes No

Are your ankles often badly swollen?..... Yes No

Have you ever had open heart surgery?..... Yes No

Have you ever had a stroke?..... Yes No

Have you ever had excessive bleeding following extraction of teeth or from a cut?..... Yes No

Do you take aspirin daily?..... Yes No

RESPIRATORY

Do you have asthma or TB?..... Yes No

Do you have emphysema?..... Yes No

GASTRO-INTESTINAL

Do you suffer from ulcers or colitis?..... Yes No

Have you ever had liver trouble or hepatitis?..... Yes No

Have you gained or lost weight recently?..... Yes No

Have you ever had yellow jaundice?..... Yes No

GENITO-URINARY

Are you thirsty much of the time..... Yes No

Do you have kidney or bladder trouble?..... Yes No

Do you have to get up every night to urinate..... Yes No

Have you ever had syphilis, gonorrhea, or Herpes II?..... Yes No

ENDOCRINE SYSTEM — Circle One

Have you ever had diabetes?..... Yes No

Has a member of your family had diabetes?..... Yes No

Have you ever taken thyroid tablets?..... Yes No

Do you get tired easily?..... Yes No

NERVOUS SYSTEM

Have you ever had a nervous breakdown?..... Yes No

Have you ever had epilepsy?..... Yes No

Do you consider yourself a nervous person?..... Yes No

FEMALE

Are you pregnant?..... Yes No

Are you on Birth Control Pills?..... Yes No

DENTAL HISTORY

Do your gums bleed when you brush your teeth?..... Yes No

Have you ever had gum treatments?..... Yes No

Have you ever had trench mouth or gingivitis?..... Yes No

Do your teeth feel sore or long when you bite?..... Yes No

Do your jaws feel tired at the end of the day?..... Yes No

Do your jaws feel tired when you awaken?..... Yes No

Do you think your teeth are moving or drifting?..... Yes No

Do you ever grind or clench your teeth?..... Yes No

Are any teeth sensitive to hot or cold?..... Yes No

Are you aware of any loose teeth?..... Yes No

Are you aware of any bone loss from around Your teeth?..... Yes No

Are you aware of any pocketing around your teeth?..... Yes No

Are your teeth important to you?..... Yes No

What concerns you most about dental treatment?_____

_____

_____

_____

Weight _____

Blood Pressure _____

Patient's Signature _____

Date: _____

To our Patients,

We will be glad to call your insurance company to verify your coverage for periodontal procedures. For your information, the insurance company will give us only an estimate. Predetermination is not a guarantee of payment. The estimate is based on “usual and customary” fee for a procedure. Our fee may be above, at, or below UCR. We assure you that you will receive excellent care.

The insurance company can only tell us your maximum coverage for the year, a percentage of what they cover on the particular procedure, based on UCR, and any deductible that you may have.

Please return this signed for along with your new patient form at your appointment.

Thank you

_____

Signature of Patient