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DIPLOMATE, AMERICAN BOARD OF PERIODONTOLOGY

PATIENT INFORMATION...

Date _____

Mr. Mrs. Ms. Dr. First Name _____ M.I. _____ Last Name _____ Nickname _____
Sex: Male Female Birth Date _____ Age _____ Soc. Sec. # _____ E-mail _____
Street _____ City _____ State _____ Zip _____
Home Tel.(_____) _____ Cell.(_____) _____ Have you ever been a patient of our practice? Yes No
Dentist _____ Medical Doctor _____ Referred By _____
Driver's Lic.# _____ Nearest relative not living with you _____ Tel.(_____) _____
Employer _____ Bus. Tel.(_____) _____ Personal Payment Type: Cash Check Credit Card
In case of emergency, please contact _____ Tel. (_____) _____ Relation _____

WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT...

Self (If self, skip this section) Spouse Father Mother Other _____
Name _____ S.S.# _____ Birth Date _____ Age _____ Tel.(_____) _____
Street _____ City _____ State _____ Zip _____
Employer _____ Bus. Tel.(_____) _____

SPOUSE OR OTHER GUARANTOR INFORMATION (if different from above)...

Name _____ Relation _____ S.S.# _____ Birth Date _____
Street _____ City _____ State _____ Zip _____
Tel. (_____) _____ Employer _____ Bus. Tel.(_____) _____

INSURANCE INFORMATION...

Student:..... Full Time Part Time Not..... School Name and Address _____
Marital Status:..... Married Divorced Widow Single Legally Separated _____
Employed:..... Full Time Part Time Retired Not..... Do you belong to a PPO or HMO? Yes No

PRIMARY INSURANCE COMPANY...

Insurance Type: Dental Medical
Employer _____
Bus. Address _____
Bus. Tel.(_____) _____ Plan _____
Ins. Co. Name _____
Address _____
_____ Tel.(_____) _____
Group # _____ **Group Name** _____
Insured Party _____ Relation _____
Sex: M F Birth Date _____
Street _____ City _____
State, Zip _____ Tel.(_____) _____
S.S. # _____ I.D. # _____

SECONDARY INSURANCE COMPANY...

Insurance Type: Dental Medical
Employer _____
Bus. Address _____
Bus. Tel.(_____) _____ Plan _____
Ins. Co. Name _____
Address _____
_____ Tel.(_____) _____
Group # _____ **Group Name** _____
Insured Party _____ Relation _____
Sex: M F Birth Date _____
Street _____ City _____
State, Zip _____ Tel.(_____) _____
S.S. # _____ I.D. # _____

DENTAL INFORMATION...

Reason for today's visit: _____ Are you in pain? Yes No, For How Long? _____

Please indicate any of the following problems by checking off the corresponding box:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Discomfort, clicking, or popping in jaw | <input type="checkbox"/> Lost / broken filling(s) | <input type="checkbox"/> Stained teeth | <input type="checkbox"/> Difficulty closing jaw |
| <input type="checkbox"/> Red, swollen, or bleeding gums | <input type="checkbox"/> Teeth grinding / clenching | <input type="checkbox"/> Locking jaw | <input type="checkbox"/> Difficulty opening jaw |
| <input type="checkbox"/> A removable dental appliance | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Bad breath | <input type="checkbox"/> Loose / shifting teeth |
| <input type="checkbox"/> Blisters / sores in or around the mouth | <input type="checkbox"/> Broken / chipped tooth | <input type="checkbox"/> Burning tongue / lips | <input type="checkbox"/> Food caught between teeth |
| <input type="checkbox"/> Prolonged bleeding from an injury / extraction | <input type="checkbox"/> Gum disease | <input type="checkbox"/> Toothache | <input type="checkbox"/> Swelling / lumps in mouth |
| <input type="checkbox"/> Recent infections or sore throat | <input type="checkbox"/> Other _____ | | |
| <input type="checkbox"/> My teeth are sensitive to: <input type="checkbox"/> Hot <input type="checkbox"/> Cold | | | |
| <input type="checkbox"/> Sweets <input type="checkbox"/> Biting | | | |

Last dental exam _____ Last dental x-rays _____ Times a day you brush? _____ Times a week you floss? _____

How would you rate your smile? (worst) 1 2 3 4 5 6 7 8 9 10 (best) Would you like whiter teeth? Yes No

What type of toothbrush bristles do you use? Soft Medium Hard

MEDICAL HISTORY...

Are you in good health? Yes No Height _____ Weight _____ Are you under the care of a physician? Yes No

Have you had any illness, operation, or been hospitalized in the past five years? Yes No

Do you have, or have you had, any of the following diseases, medical conditions, or procedures?

- | | | | |
|---|--|---|--|
| Y N
<input type="checkbox"/> <input type="checkbox"/> Rheumatic fever
<input type="checkbox"/> <input type="checkbox"/> Mitral valve prolapse
<input type="checkbox"/> <input type="checkbox"/> Heart murmur
<input type="checkbox"/> <input type="checkbox"/> High blood pressure
<input type="checkbox"/> <input type="checkbox"/> Low blood pressure
<input type="checkbox"/> <input type="checkbox"/> Chest pain / Angina
<input type="checkbox"/> <input type="checkbox"/> Heart attack(s)
<input type="checkbox"/> <input type="checkbox"/> Irregular heart beat
<input type="checkbox"/> <input type="checkbox"/> Cardiac pacemaker
<input type="checkbox"/> <input type="checkbox"/> Heart surgery
<input type="checkbox"/> <input type="checkbox"/> Bronchitis / Chronic cough
<input type="checkbox"/> <input type="checkbox"/> Chronic fatigue / Night sweat
<input type="checkbox"/> <input type="checkbox"/> Difficulty climbing 1-2 flights of stairs
<input type="checkbox"/> <input type="checkbox"/> Mental health problems
<input type="checkbox"/> <input type="checkbox"/> Damaged heart valves | Y N
<input type="checkbox"/> <input type="checkbox"/> Are you immunosuppressed? (possibly from transplant surg.)
<input type="checkbox"/> <input type="checkbox"/> Asthma
<input type="checkbox"/> <input type="checkbox"/> Hay fever / Sinus problems
<input type="checkbox"/> <input type="checkbox"/> Snoring / Sleep apnea
<input type="checkbox"/> <input type="checkbox"/> Respiratory problems
<input type="checkbox"/> <input type="checkbox"/> Tuberculosis
<input type="checkbox"/> <input type="checkbox"/> Emphysema
<input type="checkbox"/> <input type="checkbox"/> Do you smoke
<input type="checkbox"/> <input type="checkbox"/> Do you use chewing tobacco
<input type="checkbox"/> <input type="checkbox"/> Blood transfusion
<input type="checkbox"/> <input type="checkbox"/> Blood disorder
<input type="checkbox"/> <input type="checkbox"/> Bruise easily
<input type="checkbox"/> <input type="checkbox"/> A history of drug abuse
<input type="checkbox"/> <input type="checkbox"/> Eye disease / Glaucoma
<input type="checkbox"/> <input type="checkbox"/> Abnormal bleeding | Y N
<input type="checkbox"/> <input type="checkbox"/> Problems w/ immune system? (possibly from med. / surg.)
<input type="checkbox"/> <input type="checkbox"/> Bleeding tendency
<input type="checkbox"/> <input type="checkbox"/> Jaundice / Liver disease
<input type="checkbox"/> <input type="checkbox"/> Hepatitis
<input type="checkbox"/> <input type="checkbox"/> Infectious mononucleosis
<input type="checkbox"/> <input type="checkbox"/> Gallbladder trouble
<input type="checkbox"/> <input type="checkbox"/> Fainting spells
<input type="checkbox"/> <input type="checkbox"/> Convulsions / Epilepsy
<input type="checkbox"/> <input type="checkbox"/> Stroke
<input type="checkbox"/> <input type="checkbox"/> Thyroid trouble
<input type="checkbox"/> <input type="checkbox"/> Diabetes
<input type="checkbox"/> <input type="checkbox"/> A history of alcohol abuse
<input type="checkbox"/> <input type="checkbox"/> Sexually transmitted diseases
<input type="checkbox"/> <input type="checkbox"/> Swollen ankles
<input type="checkbox"/> <input type="checkbox"/> Malignant hyperthermia | Y N
<input type="checkbox"/> <input type="checkbox"/> Low blood sugar
<input type="checkbox"/> <input type="checkbox"/> Kidney trouble
<input type="checkbox"/> <input type="checkbox"/> Are you on dialysis
<input type="checkbox"/> <input type="checkbox"/> Arthritis / Joint disease
<input type="checkbox"/> <input type="checkbox"/> Osteoporosis / Osteopenia
<input type="checkbox"/> <input type="checkbox"/> Osteonecrosis
<input type="checkbox"/> <input type="checkbox"/> Stomach ulcers
<input type="checkbox"/> <input type="checkbox"/> Contagious diseases
<input type="checkbox"/> <input type="checkbox"/> Delay in healing
<input type="checkbox"/> <input type="checkbox"/> Anemia
<input type="checkbox"/> <input type="checkbox"/> Tumor or growth
<input type="checkbox"/> <input type="checkbox"/> Radiation / Chemotherapy
<input type="checkbox"/> <input type="checkbox"/> Are you on a diet
<input type="checkbox"/> <input type="checkbox"/> Contact lenses
<input type="checkbox"/> <input type="checkbox"/> Immune system problems |
|---|--|---|--|

MEDICATION & ALLERGIES...

Are you now taking or have you taken:

- | | | | |
|---|---|--|---|
| Y N
<input type="checkbox"/> <input type="checkbox"/> Nerve pills
<input type="checkbox"/> <input type="checkbox"/> Have you ever taken diet pills
<input type="checkbox"/> <input type="checkbox"/> Blood thinners (Coumadin, Aspirin, Advil)
<input type="checkbox"/> <input type="checkbox"/> Any bone density medication or Bisphosphonates (Aredia, Zometa, Fosamax, Actonel) | Y N
<input type="checkbox"/> <input type="checkbox"/> Pain killers (including aspirin)
<input type="checkbox"/> <input type="checkbox"/> Tranquilizers | Y N
<input type="checkbox"/> <input type="checkbox"/> Muscle relaxers
<input type="checkbox"/> <input type="checkbox"/> Insulin | Y N
<input type="checkbox"/> <input type="checkbox"/> Stimulants
<input type="checkbox"/> <input type="checkbox"/> Antidepressants |
|---|---|--|---|
- Please list any other medication(s) you are taking (including natural, herbal, or homeopathic products):*
-

Are you allergic to or had a reaction to:

- | | | | |
|--|---|--|--|
| Y N
<input type="checkbox"/> <input type="checkbox"/> Penicillin
<input type="checkbox"/> <input type="checkbox"/> Valium or other tranquilizers
<input type="checkbox"/> <input type="checkbox"/> Soy | Y N
<input type="checkbox"/> <input type="checkbox"/> Sulfa drugs
<input type="checkbox"/> <input type="checkbox"/> Aspirin
<input type="checkbox"/> <input type="checkbox"/> Eggs / Yolk | Y N
<input type="checkbox"/> <input type="checkbox"/> Local anesthetic (numbing med)
<input type="checkbox"/> <input type="checkbox"/> Codeine or other narcotics
<input type="checkbox"/> <input type="checkbox"/> Sulfites | Y N
<input type="checkbox"/> <input type="checkbox"/> Sodium pentothal
<input type="checkbox"/> <input type="checkbox"/> Latex
<input type="checkbox"/> <input type="checkbox"/> Amoxicillin |
|--|---|--|--|
- Please list any other medication or antibiotic you are allergic to:*
-
- Please list any allergies other than drug allergies:*
-

1-4 below for women only: (women note: antibiotics (such as penicillin) may alter the effectiveness of birth control pills. consult your physician / gynecologist for assistance regarding additional methods of birth control.)

- 1) Is there a possibility of pregnancy? Yes No 2) Expected delivery date: _____
- 3) Are you nursing? Yes No 4) Are you taking birth control pills: Yes No

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his / her staff, responsible for any errors or omissions that I have made in the completion of this form.

X _____ X _____ X _____
Signature of patient (Parent or Guardian if Minor) Reviewed by Date

FEES & PAYMENTS

We make every effort to keep down the cost of your care. You can help by paying upon completion of each visit. Other arrangements can be made with our office manager depending upon special circumstances. An estimate of the charge for any procedure or surgery you may require will be given to you upon request. If you have any dental and/or medical insurance we will be glad to fill out the proper forms, but please complete the identifying information on this form.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company.** You will be responsible for all collection costs, attorneys fees, and court costs.

X _____ X _____
Signature of patient (Parent or Guardian if Minor) Date

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

X _____ X _____
Signature of patient: (Parent or Guardian if Minor) Date

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

X _____ X _____
Signature of patient (Parent or Guardian if minor) Date