

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 _____ Cell Phone _____
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 _____

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 medicines?..... 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 a 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, gonorrhoea 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 form along with your new patient form at your appointment.

Thank you

Signature of Patient