Welcome

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PERIODONTICS AND IMPLANT SURGERY

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PERSONAL INFORMATION

Today's Date: _____

Name: _____
LAST FIRST MI MR MRS MS DR

I prefer to be called: _____

Birthdate: _____ Age: _____ SS #: _____

Home address: _____

_____
CITY STATE ZIP

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Home #: ( )_____ Pager/Other #: ( )_____

Work #: ( )_____ Ext. _____ DL #: _____

Employer: _____

Employer's address: _____

How long there? _____ Occupation: _____

Where and when are the best times to reach you? _____

Who may we thank for referring you? _____

Other family members seen by us: _____

Previous / Present Dentist: _____
(Please Circle)

Last Visit Date: _____

SPOUSE INFORMATION

Spouse Name: _____

Address: _____

Employer: _____

Home #:( )_____ Work #:( )_____ Ext. _____

Birthdate: _____ SS #: _____

Person Responsible for Account: _____

Home #:( )_____ Work #:( )_____ Ext. _____

Billing Address: _____

Relationship: _____ SS #: _____

Employer: _____ DL #: _____

DENTAL INSURANCE

Primary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: _____ Insured's SS #: _____

Insured's Employer: _____

Secondary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (Plan, Local or Policy #): _____
(Please Circle)

Insured's Name: _____ Relation: _____

Insured's Birthdate: _____ Insured's SS #: _____

Insured's Employer: _____

Our office bills dental insurance as a courtesy to our patients and is NOT a guarantee of payment. It is the patient's responsibility to be aware of their own dental coverage including calendar year or contracted year restrictions for maximums, deductibles and percentages.

ASSIGNMENT & RELEASE

I hereby authorize my dental insurance benefits be paid directly to the dentist and I am financially responsible for non-covered services. I also authorize the dentist to release any information required in the processing of my claims.

Signed: _____ Date: _____

DENTAL HISTORY

Why have you come to the dentist today? _____

_____

Are you currently in pain? ☐ No ☐ Yes

Have you ever had a serious / difficult problem associated with any previous dental work? ☐ No ☐ Yes

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? ☐ No ☐ Yes

Do you smoke? ☐ No ☐ Yes

How much? _____ packs / day.

MEDICAL HISTORY

Physician's Name: _____

Phone #: ( ) _____ Date of Last Visit: _____

Your Current dental health is: ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? ☐ No ☐ Yes

Please explain: _____

_____

Are you taking any prescription / over-the-counter drugs? ☐ No ☐ Yes

Please List each one: _____

_____

_____

_____

_____

For Women Are you taking birth control pills? ☐ No ☐ Yes

Are you pregnant? ☐ No ☐ Yes

Are you nursing? ☐ No ☐ Yes

Does your doctor recommend antibiotic premedication for any dental treatment? ☐ No ☐ Yes

If yes, Please explain: _____

_____

_____

In the event of an emergency, is there someone who lives near you that we should contact?

Name: _____ Relation: _____

Home #: ( ) _____ Work #: ( ) _____

Have you ever had any of the following diseases or medical problems?

Y	N	Heart Attack / Stroke	Y	N	Psychiatric Problems
Y	N	Cancer / Chemotherapy	Y	N	Epilepsy/Seizures/Fainting Spells
Y	N	Heart Murmur	Y	N	Diabetes / Tuberculosis (TB)
Y	N	Rheumatic Fever	Y	N	Drug / Alcohol Abuse
Y	N	HIV+ / AIDS	Y	N	Venereal Disease
Y	N	Heart Surgery / Pacemaker	Y	N	Hemophilia / Abnormal Bleeding
Y	N	Shingles	Y	N	Ulcers / Colitis
Y	N	Mitral Valve Prolapse	Y	N	Congenital Heart Disease
Y	N	Kidney Problems	Y	N	Anemia / Radiation Treatment
Y	N	Artificial Bones / Joints	Y	N	Asthma / Arthritis
Y	N	Artificial Valves	Y	N	Difficulty Breathing
Y	N	Sinus Problems	Y	N	Hospitalized for Any Reason
Y	N	High / Low Blood Pressure	Y	N	Hepatitis
Y	N	Fever Blisters	Y	N	Blood Transfusion
Y	N	Severe / Frequent Headaches	Y	N	Emphysema / Glaucoma
			Y	N	Prior use of Phen / Fen

Please list any serious medical condition(s) that you ever had:

_____

_____

_____

Are you allergic to any of the following drugs?

Y	N	Penicillin	Y	N	Tetracycline	Y	N	Latex
Y	N	Aspirin	Y	N	Dental Anesthetics	Y	N	Other
Y	N	Erythromycin	Y	N	Codeine			

Please list any other drugs that you are allergic to: _____

_____

_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in the medical status. I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment.

Signed: _____ Date: _____

OFFICE USE ONLY • OFFICE USE ONLY • OFFICE USE ONLY • OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the patient named herein. Initials_____ Date_____

Doctor's Comments: _____

_____

_____

Doctor's Comments:

1. Date_____ Comments _____ Signature _____
2. Date_____ Comments _____ Signature _____
3. Date_____ Comments _____ Signature _____