PRACTICE LIMITED TO PERIODONTICS, IMPLANTS & COSMETIC PERIODONTICS

WELCOME / HEALTH HISTORY

ABOUT YOU: TODAY'S DATE: ____________________

Name:____
Last First MI (Mr. Mrs. Ms. Dr.)

Home Address:____

____
City State Zip Apt/Condo#

Home phone#:_______________________ Wk phone#: ___________________Ext:_______ Cell Phone:____________________

__ MALE __FEMALE BIRTHDATE____/____/____ SS#:_________/______/______

__Single __Married __Divorced Driver's License #____ Exp. Date __________

E-mail address:____ Employer:____

Employer's Address: ____

Occupation: ___________________________ Preferred method for communication and confirmation: telephone email

Whom may we thank for referring you? ____

Other family members seen by us? ____

General Dentist: _________________________________ Last Visit Date:_____________________

SPOUSE INFORMATION:

Name:____

Employer:____ Wk Phone#:______________________ Ext:_____________

SS#:____/_____/_____ Birthdate:_____________ Driver's License # ___________________________ Exp. Date___________

PERSON RESPONSIBLE FOR ACCOUNT:

Name:____ Relationship: ___________________________ SS#:____/____/_____

Home Phone#:___________________________________ Work Phone#: ______________________________ Ext: ____________

Billing Address:____

Employer:__________________________________ Driver 's License # _______________________________ Exp. Date ________

DENTAL INSURANCE:

Primary Dental Insurance

Insurance Co. Name :____

Ins. Co. Address:____

_____________________________Group # (policy #) : __________________

Ins. Co. Phone #:_______________________________ ________________

Insured's Name: __________________________Relation: ______________

Insured's Birthday:_____/_____/_____ Insured's SS# : ______/______/______

Insured's Employer____

Secondary Dental Insurance

Insurance Co. Name:____

Ins. Co. Address:____

__________________________Group# (policy #):__________________

Ins. Co. Phone #:____

Insured's Name: _______________________Relation: _____________

Insured's Birthday:_____/____/____ Insured's SS#: _____/_____/_____

Insured's Employer____

EMERGENCIES:

In the event of an emergency, who may we contact? ____

Relation to you: ________________________________ Home Phone:________________________ Work Phone:___________________

MEDICAL HISTORY:

Reason for this visit ________________________ When was your last visit ______________ Previous Dentist __________________________

Physician's Name:____ Phone #:____________________ Date of last visit: _________________

Your current physical health is ____ Good ___ Fair ___ Poor Are you currently under the care of a physician? _____Yes _____ No

If YES please explain: _____________________________________ Are you taking any prescription/over the counter drugs? ___Yes ___No

Please list ANY/ALL medications:____

Are you taking any blood thinners or aspirin? ____Yes ____ No If yes, please list which one(s) ____________________________________

FOR WOMEN: Are you taking birth control pills? ___Yes ___ No Are you pregnant? ___Yes ___No Are you nursing? ___Yes___No

HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS?

Y	N		Y	N		Y	N	
_	_	Heart attack/Stroke	_	_	Anemia	_	_	Severe/Frequent Headaches
_	_	Heart Surgery/Pacemaker	_	_	Asthma	_	_	Epilepsy/Seizures/Fainting
_	_	High/Low Blood Pressure	_	_	Emphysema/Tuberculosis(T.B)	_	_	Glaucoma/Cataracts
_	_	Rheumatic Fever	_	_	Sinus Problems	_	_	Psychiatric Problems
_	_	Mitral Valve Prolapse (with regurgitation)	_	_	Shingles/Fever Blisters	_	_	Drug/Alcohol Abuse
_	_	Artificial Valves	_	_	HIV + / AIDS	_	_	Arthritis
_	_	Congenital Heart Defect	_	_	Venereal Disease	_	_	Artificial Bones/Joints
_	_	Blood Transfusion	_	_	Kidney Problems	_	_	Cancer/Chemo/radiation tx
_	_	Heart Murmur	_	_	Hepatitis	_	_	Ulcers/Colitis
_	_	Hemophilia/Abnormal Bleeding	_	_	Diabetes	_	_	Hospitalized for any reason

ARE YOU ALLERGIC TO THE FOLLOWING?

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

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 MY 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.

Signature____ Date______________________________________

PAYMENT ALTERNATIVES:

Payment is due in full at the time of treatment unless prior arrangements have been made approved.

1. Cash and personal check are accepted as your treatments are provided.
2. If you have dental insurance, we want you to receive the full benefit of it. Our office staff can assist you in verifying the coverage that your particular coverage provides. We will submit your insurance for you; another service to you. This means that you are responsible to pay and we will have the insurance company send payment to you for what they cover.
3. We accept Mastercard, Visa, American Express, and Discover.

THE PATIENT WILL BE RESPONSIBLE FOR ANY CHARGES AND COSTS INCURRED IN THE PROCESS OF COLLECTING DELINQUENT ACCOUNTS, INCLUDING ATTORNEY FEES. 1.75% PER MONTH WILL BE CHARGED TO ACCOUNTS OVER 90 DAYS.

Signature____ Date______________________________________