PATIENT INFORMATION

Full Name: _____ Preferred Name: _____

Date of Birth: _____/_____/_____ SSN:_____-_____-_____ DL#: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (_____) _____ Email address_____

Cell Phone: (_____) _____ Sex: ☐ Male Marital Status: ☐ Single ☐ Married ☐ Divorced

Work Number: (_____) _____ ☐Female ☐ Separated ☐ Widowed

ACCOUNT INFORMATION

Who is responsible for paying this account? _____

Relationship to patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other: _____

Responsible party's Full Name_____ DOB: _____/_____/_____

SSN: _____DL#:_____

Address:_____City_____ State_____Zip Code:_____

Employer: _____ Employer's Phone:_____

Is the patient is a minor or dependent? If so, please provide the following:

Father's Name:_____ Mother's Name:_____

Phone(s):_____ Phone(s):_____

SSN: _____ SSN:_____

DOB:____/_____/_____ DL#:_____ DOB:_____/_____/_____ DL#:_____

Employer Name/Phone #:_____/_____ Employer Name/Phone #:_____/_____

DENTAL INFORMATION

Please indicate if you have a preference for the following dentists: ☐ No Preference ☐ Dr. Pat ☐ Dr. Jan

Previous Dentist: _____ Date of last dental exam: _____

How do you feel about your smile? _____

What, if anything, would you change about your smile?_____

Yes	No		Yes	No	
☐	☐	Do your gums bleed when you brush?	☐	☐	Have you ever had your teeth straightened?
☐	☐	Have you ever been diagnosed as having periodontal (gum) disease?	☐	☐	Are you aware of grinding or clenching your teeth?
☐	☐	Have you ever experienced a problem with local anesthesia?	☐	☐	Have you ever had TMJ treatment?
☐	☐	Do you get frequent blisters on your lips or in your mouth?	☐	☐	Do you have removable appliance (denture/partial)?

☐ ☐ Are you aware of any oral habits such as thumb sucking, nail biting, mouth breathing? (circle one)

☐ ☐ Are your teeth sensitive to heat, cold, sweets, or pressure? (circle one)

☐ ☐ Do you have any discomfort in your mouth presently? Specify_____

☐ ☐ Do you have pain or clicking when opening or closing your jaw?

☐ ☐ Are you aware of any swelling or lump in your mouth? Specify_____

REFERRAL INFORMATION:

Whom may we thank for referring you to our office? ☐ Website ☐ Phonebook ☐ Insurance ☐ Other: _____

MEDICAL INFORMATION

Yes No

☐ ☐ Have you ever had your wisdom teeth extracted? If yes, when? _____
☐ ☐ Have you ever experienced a problem with local anesthesia?
☐ ☐ Have you ever had a serious head or neck injury?
☐ ☐ Have you ever been hospitalized or had a major operation?
☐ ☐ Are you taking any medications, pills, or drugs? If so, please explain: _____
☐ ☐ Are you on a special diet?
☐ ☐ Do you use tobacco?
☐ ☐ Do you take, or have you taken Phen-Fen or Redux?
☐ ☐ Do you use controlled substances?
☐ ☐ Do you take bisphosphonates (Fosamax, Boniva, etc.)?
☐ ☐ Do you take Aspirin?
☐ ☐ Do you take a Blood Thinner (Warfarin, Coumadin, etc)?

Are you currently under the care of a physician? ☐ Yes ☐ No Physician Name/Phone #:_____/_____

If yes, what is/are the condition(s) being treated? _____

Women, Are you ☐ pregnant/trying to get pregnant? ☐ nursing? ☐ taking oral contraceptives?

Are you allergic to any of the following? ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex

☐ Local Anesthetics ☐ Other – Please specify: _____

Do you have, or have you had, any of the following?

☐ AIDS/HIV Positive
☐ Artificial Heart Valve
☐ Chemotherapy
☐ Diabetes
☐ Excessive Bleeding
☐ Heart Attack/Failure
☐ Heart Murmur
☐ Artificial Joint, if so when_____
☐ Heart Pace Maker
☐ Heart Trouble/Disease
☐ Hepatitis A
☐ Hepatitis B or C
☐ High Blood Pressure
☐ Liver Disease
☐ Mitral Valve Prolapse
☐ Rheumatic Fever
☐ Stroke
☐ Tuberculosis
☐ Persistent Cough that produces blood or persistent cough lasting longer than 3 weeks

CONSENT:

The undersigned hereby authorizes Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medications, and therapy that may be in connection with (Patient's Name) _____ and further authorize and consent that Doctor choose and employ such assistance as deemed fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other financial arrangements have been made prior to the time of service. I further understand that a $10.00 rebilling fee will be added to any balance over 90 days. In the event of default (We) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

Patient Signature _____ Date _____

Parent Signature (for minors/dependents) _____ Date _____

Relationship to Patient _____

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

NAME: _____

ADDRESS: _____

TELEPHONE: _____ CELL PHONE:_____

WORK NUMBER:_____ E-MAIL: _____

DATE OF BIRTH:_____ SOCIAL SECURITY NUMBER: _____-_____-_____

INSURANCE COMPANY:_____

SUBSCRIBER NAME (POLICY HOLDER):_____

SUBSCRIBER NUMBER OR SSN:_____ POLICY NUMBER:_____

SUBSCRIBER DATE OF BIRTH:_____

SUBSCRIBER PLACE OF EMPLOYMENT:_____

SUBSCRIBER ADDRESS (if different than patient address):_____

_____

RELATIONSHIP TO SUBSCRIBER (please circle):

SELF SPOUSE CHILD OTHER

TO THE PATIENT- PLEASE READ THE FOLLOWING STATEMENTS:

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of protected health information, and of other important matters about your protected health information. A copy or our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions or our Notices, at any time by contacting our office.

Right to revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or continue treating you in you revoke this Consent.

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this consent is signed by a personal representative on behalf of the patient, please complete the following:
Representative Name: _____ Relationship to Patient: _____

My protected personal health information may be disclosed to the following person(s) until such time as I choose to revoke it in writing:

_____

_____

Please indicate relationship to the patient for each person listed above.

Periodontal Risk Assessment Questionnaire

Name _____ Date _____

Tobacco Use

Tobacco use is the most significant risk factor for gum disease.

Do you now or have you ever used the following:

	Amounts per day	Used for how many years	If you quit, list what year
❑ Cigarette			
❑ Cigar			
❑ Pipe			
❑ Chewing			

Blood Sugar

Diabetes

Gum disease is a common complication of diabetes. Untreated gum disease makes it harder for patients with diabetes to control their blood sugar.

IF YOU ARE A PATIENT WHO HAS DIABETES:

Is your diabetes under control? ❑ Yes ❑ No

Are you prone to diabetic complications? ❑ Yes ❑ No

How do you monitor your blood sugar? _____

Who is your physician for diabetes? _____

IF YOU ARE NOT A PATIENT WHO HAS DIABETES:

Any family history of diabetes? ❑ Yes ❑ No

Have you had any of these warning signs of diabetes?

- ❑ frequent urination
- ❑ excessive thirst
- ❑ excessive hunger
- ❑ weakness and fatigue
- ❑ slow healing of cuts
- ❑ unexplained weight loss

Heart Attack/Stroke

Untreated gum disease may increase your risk for heart attack or stroke.

Do you have any risk factors for heart disease or stroke?

- ❑ Family history of heart disease
- ❑ Tobacco use
- ❑ Obesity
- ❑ High cholesterol
- ❑ High blood pressure

If you have any of these other risk factors it is especially important for you to always keep your gums as healthy as possible.

Medications

A side effect of some medications can cause changes in your gums.

Are you taking or have you ever taken any of the following medication:

❑ Antiseizure medications. (such as Dilantin®, Tegretol®, Phenobarbital, etc.)

❑ Yes ❑ No

If you answered yes, are you still taking the anti-seizure medication?

❑ Yes ❑ No

Other Medication: _____

❑ Calcium Channel Blocker blood pressure medication. (such as Procardia®, Cardizem®, Norvasc®, Verapamil®, etc.)

Other: _____

❑ Immunosuppressant therapy (such as Prednisone, Azathioprine, Cyclosporins, Corticosteriods (Asthma-Inhalers), etc.)

Other: _____

Family History/ Genetics

The tendency for gum disease to develop can be inherited.

Is there an immediate family member(s) who currently has or had gum problems in the past? (e.g. your mother, father, or siblings):

❑ Yes ❑ No

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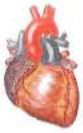

Heart Murmur, Artificial joint prosthesis

If you have even the slightest amount of gum inflammation, bacteria from the mouth can enter the bloodstream and may cause a serious infection of the heart or joints.

Do you have a heart murmur or artificial joint?

❑ Yes ❑ No

If so, does your physician recommend antibiotics prior to dental visits?

❑ Yes ❑ No

Name of physician? _____

If you answered yes, it is especially important to always keep your gums as healthy and inflammation-free as possible to reduce the chance of bacterial infection originating from the mouth.

Females

Females can be at increased risk for gum disease at different points in their lives.

The following can adversely affect your gums. Please check all that apply:

❑ Pregnant ❑ Nursing ❑ Menopause

❑ Taking birth control pills

❑ Infrequent care during previous pregnancies

Women

Women with osteoporosis have a greater risk for periodontal bone loss.

Females:

Do you take any of the following:

❑ Estrogen Replacement Therapy/Hormone Replacement Therapy (such as Prempro®, Premarin®, Premphase®, Fosamax®, Actonel®, Evista®, Fortéo®, etc.)

Other: _____

Stress

High levels of stress can reduce your body's immune defense.

Are you under a lot of stress?

❑ Yes ❑ No

Nutrition

Your diet has the potential to affect your periodontal health.

Do you find it difficult to maintain a well-balanced diet?

❑ Yes ❑ No

All patients please complete the following:

Have you noticed any of the following signs of gum disease?

❑ Bleeding gums during toothbrushing

❑ Red, swollen or tender gums

❑ Gums that have pulled away from the teeth

❑ Persistent bad breath

❑ Pus between the teeth and gums

❑ Loose or separating teeth

❑ Change in the way your teeth fit together

❑ Food catching between teeth

Is it important to keep your teeth for as long as possible? ❑ Yes ❑ Not really

If you have missing teeth, why have you not had them replaced? _____

Do you like the appearance of your smile? ❑ Yes ❑ No

Do you like the color of your teeth? ❑ Yes ❑ No

Do your teeth keep you from eating any specific food? ❑ Yes ❑ No

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