WELCOME TO OUR OFFICE
PERIODONTAL ASSOCIATES

Date_____

Patient's Name _____ Preferred Name or Nickname _____

Date of Birth _____ Social Security # _____

Name of Spouse _____

If a Child, Parent's Name _____

Residence Address _____ Apt._____

City _____ State_____ Zip_____

Telephone: Residence (____)_____ Cell (____) _____ Business (____)_____Ext.____

E-Mail Address _____ Fax No. _____

Please check where you want us to confirm your appointments: ☐ Residence ☐ Cell ☐ Business ☐ E-Mail

Employed By_____ Position _____

Business Address _____ City_____ State____ Zip_____

Spouse Employed By _____ Business Phone _____

Whom may we thank for referring you? _____

Who is your general dentist at this time? _____

Nearest relative not living with you _____ Telephone # (____) _____

Contact in case of emergency_____ Telephone # (____) _____

Person Responsible for payment of Account _____

(name, address, telephone if different than above)

DENTAL INSURANCE

Primary Dental Insurance

Your dental insurance is through (check one):
___your employer ___your spouse's employer ___other
Employee's full name:

_____

Employee's Date of Birth _____

Employee's Social Security # _____

Employer's Name_____

Employer's Address _____

Insurance Name _____

Insurance Address _____

Policy # _____ Group #_____

Employer ID #_____ Union Local #_____

Insurance Co. Phone (_____) _____

Secondary Dental Insurance (if you have dual coverage)

Your secondary dental insurance is through (check one):
___your employer ___your spouse's employer ___other
Employee's full name:

_____

Employee's Date of Birth _____

Employee's Social Security # _____

Employer's Name_____

Employer's Address _____

Insurance Name _____

Insurance Address _____

Policy # _____ Group #_____

Employer ID #_____ Union Local #_____

Insurance Co. Phone (_____) _____

I understand that I am responsible for all costs of dental treatment and accept that should collection proceedings be instituted, attorney fees, collection expenses, interest and court costs will be imposed. I hereby authorize the release of any dental or medical records as necessary to assist in dental treatment and/or relating to all claims for benefits submitted on behalf of myself and/or dependents. I further agree and acknowledge that my signature on this document authorizes Periodontal Associates to submit claims for benefits and services rendered or to be rendered and that I will be bound by this signature as though I had personally signed the particular claim. I hereby authorize and assign direct payment of the dental benefits for such services otherwise payable to me, directly to Dr. Versman, Dr. Heller, Dr. Glick, Dr. Beckman or Periodontal Associates. This assignment shall remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

Patient's/Parent's Signature _____

Reviewed by _____ Date_____

OVER ➥

HEALTH QUESTIONNAIRE

Answers to the following questions are for our records and will be considered confidential.

1. Name and address of physician

_____

_____ Phone_____

2. Date of last medical visit: Mo:_____ Yr:_____
3. Is your general health good? Yes No
4. Is your dental health good? Yes No
5. Have you had periodontal disease in the past? Yes No
6. Are you presently being treated for any illness or medical condition? Yes No
7. Have you been hospitalized in the last 10 years? Yes No
8. Have you been sedated before? Yes No
   Any complications? _____ Yes No
9. Do you have, or have you ever had:
   - Heart trouble or heart murmur? Yes No
   - Artificial heart valve? Yes No
   - Pain in the chest or angina? Yes No
   - Heart attack (Ml)? Yes No
   - A pacemaker? Yes No
   - Shortness of breath or lung problems? Yes No
   - Hayfever or asthma? Yes No
   - Sleep apnea? Yes No
   - Snoring at night? Yes No
   - Fainting or dizziness? Yes No
   - Stroke? Yes No
   - High blood pressure? Yes No
   - Diabetes? Yes No
   - Anorexia or eating disorders? Yes No
   - Ulcers or stomach trouble? Yes No
   - Epilepsy or seizures? Yes No
   - Glaucoma? Yes No
   - Thyroid trouble? Yes No
   - Kidney or bladder trouble? Yes No
   - Neurosis or psychological problems or depression? Yes No
   - Hepatitis or jaundice? Yes No
   - Arthritis? Yes No
   - Frequent headaches? Yes No
   - Cancer or radiation treatment? Yes No
   - IV drugs? _____ Yes No
   - Osteoporosis/Osteopenia? Yes No
   - Do you take any drugs for this, i.e., Fosamax, Boniva? _____ Yes No
   - Sinus problems? Yes No
   - A transplant or implant? Yes No
   - A knee, hip or joint replacement? Yes No
   - Memory loss? Yes No
10. Have you had <u>abnormal</u> bleeding associated with previous extractions, surgery or trauma? Yes No
    Anemia? Yes No
11. Do you have the HIV (AIDS) virus or are you in a high risk group? Yes No
12. Are you allergic to, or have you reacted adversely to:
    - a. Local anesthetics (Novocaine)? Yes No
    - b. Penicillin, Tetracycline, sulfa-based drugs or other antibiotics? Yes No
    - c. Barbiturates, sedatives, sleeping pills? Yes No
    - d. Aspirin or ibuprofen? Yes No
    - e. Codeine or other narcotics? Yes No
    - f. Nitrous oxide analgesia? Yes No
    - g. Other medications? Yes No
    - h. Latex? Yes No

What drugs/medications do you take or have you taken in the past year? (Medication/Dose)

_____

_____

_____

_____

_____

Do you take aspirin/ibuprofen or pain medications on a regular basis? Yes No

Do you smoke or use tobacco? Yes No

How long?_____ How much?_____

Do you use recreational drugs? Yes No

Do you take herbal supplements or vitamins? Yes No

Do you have any condition, problem or disease not mentioned above? Yes No

Please explain _____

_____

_____

_____

13. Do you consider yourself a nervous or tense person? Yes No

Women

1. Are you pregnant or nursing? Yes No
2. Are you presently taking birth control pills? Yes No
3. Are you post-menopausal? Yes No

Your Comments or Concerns _____

_____

_____

_____