WELCOME TO OUR OFFICE
PERIODONTAL ASSOCIATES

Date_____

Patient's Name_____ Nickname_____

Date of Birth_____ Social Security #_____

Name of Spouse_____ Spouse Social Security #_____

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_____

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 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 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. Is your general health good? Yes No
3. Is your dental health good? Yes No
4. Date of last medical visit: Mo._____/Yr._____
5. Are you presently being treated for any illness or medical condition? Yes No
6. Have you been hospitalized in the last 10 years? Yes No
7. Do you have, or have you ever had:
   - Heart trouble or heart murmur Yes No
   - Rheumatic Fever Yes No
   - Pain in the chest or angina Yes No
   - A pacemaker Yes No
   - Shortness of breath or lung problems 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
   - Blood disorders (i.e. anemia) Yes No
   - Have you ever been exposed to or do you have the HIV (AIDS) virus or are you in a high risk group? Yes No
   - Epilepsy or seizures Yes No
   - Glaucoma Yes No
   - Thyroid trouble Yes No
   - Hayfever or asthma Yes No
   - Kidney or bladder trouble Yes No
   - Neurosis or psychological problems Yes No
   - Hepatitis or jaundice Yes No
   - Arthritis Yes No
   - Frequent headaches Yes No
   - Cancer or radiation treatment Yes No
   - Osteoporois Yes No
   - Sinus problems Yes No
   - A transplant or implant Yes No
   - A hip or joint replacement Yes No
8. Have you ever had <u>abnormal</u> bleeding associated with previous extractions, surgery, or trauma? Yes No
9. 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?_____

_____

_____

_____

_____

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

Do you smoke or use tobacco? Yes No

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_____

_____

_____

_____

_____

_____

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

Women

1. Are you pregnant? Yes No
2. Are you taking birth control pills? Yes No
3. Are you postmenopausal? Yes No

Your Comments or Concerns_____

_____

_____

_____