

Pennsylvania Center for Dental Implants and Periodontics

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Diplomate, American Board of Periodontology

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Patient Information

Date _____ Patient's Name _____
Last First Middle
Address _____
Street City State Zip
Home Ph. # (____) _____ Social Security # _____ Drivers License # _____
Birthday _____ If patient is a minor, give parent's/guardian's name _____
If patient is a full-time student fill in school name _____
Name of nearest relative not living with you _____ Relationship _____
Complete Address _____ Ph. # (____) _____
Emergency Contact _____ Ph. # (____) _____

Responsible Party Information

Name _____
Last First Middle Marital Status
Residence _____
Street City State Zip
Mailing Address _____
Street City State Zip
How long at this address _____ Home Ph. # (____) _____ Work Ph. # (____) _____
Previous Address (if less than 3 years) _____
Street City State Zip
Social Security # _____ Birthdate _____ Relationship to Patient _____
Employer _____ Occupation _____ No. Years Employed _____
Employer Address _____
Spouse's Name _____ Relationship to Patient _____
Last First Middle
Employer _____ Occupation _____ No. Years Employed _____
Employer Address _____
Social Security # _____ Birthdate _____ Work Ph. # (____) _____

Insurance Information

Insured's Name _____ Insured's Soc. Sec. # _____
Insurance Company _____ Group No. _____
Insurance Co. Address _____ Ph. # (____) _____
Is policy connected with your union? Yes ___ No ___ Name of Union _____ Local No. _____
Do you have dual coverage? Yes ___ No ___ If yes: **Please complete the following secondary insurance information.**
Insured's Name _____ Insured's Soc. Sec. # _____
Insurance Co. _____ Group No. _____ Local No. _____
Insurance Co. Address _____ Ph. # (____) _____
Insured's Employer _____ Ph. # (____) _____

Dental / Periodontal Information

Do you gums bleed when you brush? Yes ___ No ___
Are your teeth sensitive to heat or cold? Yes ___ No ___ Pressure? Yes ___ No ___ Sweets? Yes ___ No ___
Do you grind or clench your teeth? Yes ___ No ___
Do you have any fear of Dental work? Yes ___ No ___
Date of last dental examination _____ What was done at the time? _____
Date of last dental cleaning _____ When was cleaning prior to that visit? _____
How would you describe your current dental problem? _____

How do you feel about the appearance of your teeth? _____

Are you aware of gum disease (Periodontitis) in the family or does any family member wear partial or full dentures or are missing any teeth?
Yes ___ No ___ If yes: Whom? _____

Medical Information

1. Are you having pain or discomfort at this time? YES NO
2. Have you been a patient in the hospital during the past two years? YES NO
3. Have you been under the care of a physician during the past two years? YES NO
 Physician's Name _____ Ph. # (_____) _____
 Address _____ Last visit: _____
4. Have you taken any medication or drugs during the past two years? YES NO
5. Are you now taking any medication or drugs? (include aspirin and vitamin supplements..... YES NO
 If yes, please list: _____
6. Are you sensitive or allergic to any medication or anesthetics? YES NO
 If yes, please list: _____
7. Indicate which of the following you have had or have at present. Circle "yes" or "no" to each item.

Heart Failure	YES	NO	Artificial Joints (hip, knee, etc.)..	YES	NO	Allergy to Latex	YES	NO
Heart Disease or Attack	YES	NO	Kidney Trouble	YES	NO	Hepatitis B (serum).....	YES	NO
Angina Pectoris.....	YES	NO	Ulcers.....	YES	NO	Venereal Disease.....	YES	NO
Congenital Heart Disease	YES	NO	Diabetes.....	YES	NO	A.I.D.S.....	YES	NO
Heart Murmur	YES	NO	Thyroid Problems.....	YES	NO	H.I.V. Positive	YES	NO
High Blood Pressure.....	YES	NO	Glaucoma	YES	NO	Cold Sores/Fever Blisters	YES	NO
Arteriosclerosis	YES	NO	Cancer	YES	NO	Blood Transfusion	YES	NO
Mitral Valve Prolapse	YES	NO	Emphysema	YES	NO	Hemophilia.....	YES	NO
Artificial Heart Valve	YES	NO	Chronic Cough.....	YES	NO	Anemia.....	YES	NO
Heart Pacemaker.....	YES	NO	Tuberculosis.....	YES	NO	Sickle Cell Disease.....	YES	NO
Heart Surgery	YES	NO	Asthma.....	YES	NO	Bruise Easily.....	YES	NO
Rheumatic Fever.....	YES	NO	Hay Fever.....	YES	NO	Liver Disease	YES	NO
Arthritis	YES	NO	Allergies or Hives.....	YES	NO	Yellow Jaundice	YES	NO
Rheumatism.....	YES	NO	Sinus Trouble	YES	NO	Epilepsy or Seizures.....	YES	NO
Cortisone Medicine.....	YES	NO	Radiation Therapy.....	YES	NO	Fainting or Dizzy Spells	YES	NO
Drug Addiction	YES	NO	Chemotherapy	YES	NO	Nervousness.....	YES	NO
Stroke	YES	NO	Hepatitis A (infectious).....	YES	NO	Tumors	YES	NO
						Developmentally Disabled	YES	NO
8. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired? YES NO
9. Do your ankles swell during the day?..... YES NO
10. Do you use more than 2 pillows to sleep? YES NO
11. Have you lost or gained more than 10 pounds in the past year? YES NO
12. Do you ever wake up from sleep and feel short of breath? YES NO
13. Are you on a special diet? YES NO
14. Do you have or have you had any disease, condition, or problem not listed? YES NO
 If yes, please list: _____
15. Do you smoke cigarettes? If yes: how long and how many _____ YES NO

FOR WOMEN ONLY:

Are you pregnant? YES, what month? _____ NO Are you nursing? YES NO Are you taking birth control pills? YES NO

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient Signature _____ Date _____

CONSENT:

1. 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.
2. I authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of patient) _____. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.
3. I understand that all 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 arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1-1/2% finance charge (18% APR) may be added to my account. In addition to any collection charges.
4. I understand that where appropriate, credit bureau reports may be obtained.
5. I understand that it is my responsibility to advise your office of any changes in the information contained on this form.

Patient _____ Date _____ Witness _____

Parent of Responsible Party _____ Relationship to Patient _____

I HAVE RECEIVED A COPY OF PRIVACY PRACTICES. _____