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 ________________________________ Phone #________________________

Emergency Contact ________________________________ Phone #________________________

Insurance Information

Insured's Name ________________________________ Date of Birth________________________

Relationship to Patient ________________________________ Social Security #________________________

Insurance Company ________________________________ Insurance ID #________________________

Insurance Co. Address ________________________________ Phone #________________________

Group Name/Employer ________________________________ Group #________________________

Employer Address ________________________________ Phone #________________________

If Connected to a Union: Name of Union ________________________________ Local No.______________

Do you have dual coverage? Yes ____ No ____ If yes: **Please complete the following secondary insurance information.**

Insured's Name ________________________________ Date of Birth________________________

Relationship to Patient ________________________________ Social Security #________________________

Insurance Company ________________________________ Insurance ID #________________________

Insurance Co. Address ________________________________ Phone #________________________

Group Name/Employer ________________________________ Group #________________________

Employer Address ________________________________ Phone #________________________

If Connected to a Union: Name of Union ________________________________ Local No.______________

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? ________________________________

Please complete back page

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.

						Allergy to Latex	YES	NO
Heart Failure	YES	NO	Artificial Joints (hip, knee, etc.)	YES	NO	Hepatitis B (serum)	YES	NO
Heart Disease or Attack	YES	NO	Kidney Trouble	YES	NO	Venereal Disease	YES	NO
Angina Pectoris	YES	NO	Ulcers	YES	NO	A.I.D.S.	YES	NO
Congenital Heart Disease	YES	NO	Diabetes	YES	NO	H.I.V. Positive	YES	NO
Heart Murmur	YES	NO	Thyroid Problems	YES	NO	Cold Sores/Fever Blisters	YES	NO
High Blood Pressure	YES	NO	Glaucoma	YES	NO	Blood Transfusion	YES	NO
Arteriosclerosis	YES	NO	Cancer	YES	NO	Hemophilia	YES	NO
Mitral Valve Prolapse	YES	NO	Emphysema	YES	NO	Anemia	YES	NO
Artificial Heart Valve	YES	NO	Chronic Cough	YES	NO	Sickle Cell Disease	YES	NO
Heart Pacemaker	YES	NO	Tuberculosis	YES	NO	Bruise Easily	YES	NO
Heart Surgery	YES	NO	Asthma	YES	NO	Liver Disease	YES	NO
Rheumatic Fever	YES	NO	Hay Fever	YES	NO	Yellow Jaundice	YES	NO
Arthritis	YES	NO	Allergies or Hives	YES	NO	Epilepsy or Seizures	YES	NO
Rheumatism	YES	NO	Sinus Trouble	YES	NO	Fainting or Dizzy Spells	YES	NO
Cortisone Medicine	YES	NO	Radiation Therapy	YES	NO	Nervousness	YES	NO
Drug Addiction	YES	NO	Chemotherapy	YES	NO	Tumors	YES	NO
Stroke	YES	NO	Hepatitis A (infectious)	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. X ____