

## SUBURBAN PERIODONTICS & IMPLANT DENTISTRY

Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_  
First MI Last City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Social Security # \_\_\_\_\_

**PHONE NUMBERS**

Primary \_\_\_\_\_

Cell \_\_\_\_\_

Work Phone \_\_\_\_\_

Email \_\_\_\_\_

Date of Birth \_\_\_\_\_ Marital Status \_\_\_\_\_

Employer \_\_\_\_\_

Spouse Name \_\_\_\_\_

Social Security # \_\_\_\_\_

Date of Birth \_\_\_\_\_ Employer \_\_\_\_\_

Primary Insurance Company \_\_\_\_\_ ID# \_\_\_\_\_

Secondary Insurance Company \_\_\_\_\_ ID# \_\_\_\_\_

Who is your current dentist? \_\_\_\_\_

Length of time with dentist? \_\_\_\_\_  
Name Phone

What is your present dental problem? Are you having any discomfort or pain? \_\_\_\_\_

Have you had any previous dental experiences worth noting? \_\_\_\_\_

**PLEASE ANSWER THE FOLLOWING QUESTIONS (SELECT Y FOR YES AND N FOR NO)**

- |   |   |   |   |   |                                |
|---|---|---|---|---|--------------------------------|
| Y | N | I clench or grind my teeth during the day or while sleeping | Y | N | My gums feel tender or swollen |
| Y | N | My gums bleed while brushing or flossing                    | Y | N | I have problems eating         |
| Y | N | I snore at night  | Y | N | Sleep apnea                    |
| Y | N | High Carbohydrate intake (sugar, soda, energy drinks)       | Y | N | Dry mouth                      |
| Y | N | Are you a mouth breather?                                   | Y | N | Headaches                      |

**DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING (SELECT Y FOR YES AND N FOR NO)**

- |   |   |   |   |   |   |
|---|---|---|---|---|---|
| Y | N | Heart Disease                                   | Y | N | Are you or have you been on Fosamax, Actonel or Aredia? |
| Y | N | Heart Murmur / Mitral Valve Prolapse            |   |   | ____ Intravenous ____ Oral                              |
| Y | N | Stroke  | Y | N | Liver Disease / Hepatitis Type ____                     |
| Y | N | Rheumatic Fever                                 | Y | N | Herpes  |
| Y | N | Abnormal Blood Pressure                         | Y | N | Excessive Urination / Thirst                            |
| Y | N | Anemia  | Y | N | Infectious Mononucleosis (Mono)                         |
| Y | N | Prolonged Bleeding Disorder                     | Y | N | Diabetes / Controlled ____ Y ____ N                     |
| Y | N | Tuberculosis or Lung Disease                    | Y | N | Hay Fever   |
| Y | N | Asthma  | Y | N | Epilepsy / Seizures                                     |
| Y | N | Sexually Transmitted / Venereal Disease         | Y | N | Ulcers  |
| Y | N | Immune Suppressed Disorder (HIV or AIDS)        | Y | N | Cancer / Chemotherapy                                   |
| Y | N | Implants / Artificial Joints ____ Hip ____ Knee | Y | N | Radiation Treatment                                     |
|   |   | ____ Other _____                                | Y | N | Emotional or Nervous Disorders                          |
| Y | N | I smoke or use tobacco                          | Y | N | Anorexia or Bulimia                                     |
|   |   | If yes, how much per day? _____                 |   |   |   |

Y	N	Do you consume alcohol?	Y	N	Kidney Disease
Y	N	History of drug addiction	Y	N	Fainting Spells
Y	N	I usually take an antibiotic prior to dental treatment (pre-medicate)	Y	N	Glaucoma
Y	N	I have had major surgery Year _____ Type of Operation _____	Y	N	Pregnancy
Y	N	Have you ever been warned against taking or are you allergic to any medications? Please list: _____			
Y	N	Do you have any Latex or environmental allergies			

**PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:**

Medicine _____	Condition _____	Medicine _____	Condition _____
Medicine _____	Condition _____	Medicine _____	Condition _____
Medicine _____	Condition _____	Medicine _____	Condition _____

**IN THE EVENT OF AN EMERGENCY PLEASE CONTACT:**

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_  
 Physicians Name \_\_\_\_\_ Phone \_\_\_\_\_

To the best of my knowledge all of the above are correct. If I ever have any changes in my health, or in my medications, I will inform the doctor at the next appointment.

After explanation by the doctor I hereby authorize the performance of dental services upon the above named patient and whatever procedures that the judgment of the doctor may decide in order to carry out these procedures. I also authorize and request the administration of any anesthesia and x-rays as may be deemed necessary and advisable by the doctor.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**PATIENT CONSENT FORM**

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health and information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g. my insurance company)
- The day-to-day healthcare operations of your practice

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and healthcare operations, but they are not required to agree to these restrictions. However, if you do agree, you are bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Patient Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

<b>FOR OFFICE USE ONLY</b>									
Oral Hygiene: Methods & Frequency _____					Date of last cleaning? _____				
Signs & Symptoms	Y	N	Bleeding Gums	Y	N	Bad Taste	Y	N	
Discomfort	Y	N	Abscesses	Y	N	Mobility	Y	N	
Floss Snagging	Y	N	Sensitivity	Y	N	Recession	Y	N	
Anterior Flaring	Y	N	Tooth Movement	Y	N	Pain Chewing	Y	N	