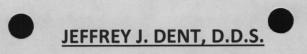


Date: Soc. Sec. No.:	Birthdate	Sex				
Full Name	Hm. Ph.:	Wk.Ph.Cell				
Mailing Address	City, State, Zip Code					
Occupation & Employer	Address	Address				
Spouse's Name	Spouse's Business Phone	Spouse's Business Phone				
Spouse's Employer	Address					
Physician's Name	Whom may we thank for re	Whom may we thank for referring you to our office?				
Dentist's Name						
Pl	RIMARY INSURANCE COMPANY					
Insurance Company and Mailing Address						
Subscriber Name Soc. Sec. No.	Subscriber Birthday					
Policy No. Group No.						
Patient's relationship to Subscriber: Self	Spouse Child					
ADULT EXAMIN	ATION AND HEALTH HISTORY QUESTIC	DNAIRE				
In order to evaluate your dental health thoroughly a become part of your	nd completely, please complete the foll r office record and will be held in strict of					
Are you experiencing pain from your mouth at the second seco	nis time? <b>yes no</b> If so, p	olease explain:				
How many times have you had your teeth cleaner						
. Have you had previous periodontal treatments? <b>yes no</b> Dentist Date						
. Are your teeth sensitive to heat, cold, or sweets? yes no Which ones?						
How often do you brush your teeth?	Floss your teeth?					
6. Would you be tremendously disturbed if you had						
7. Are your satisfied with the appearance of your teeth? yes no						
. Do you smoke? yes no What and how much?						
. Are you fearful about undergoing periodontal therapy? yes no						
Have you had an extremely frightening experience with dentistry? yes no Explain:						

11.	Please indicate the items you	egularly use to care for you	ur mouth:			
	Hand Toothbrush	Rubber St	imulator S	Stimudents	Other	
	Electric Toothbrush	Toothpick	\	Vater Spray		
	Dental Floss	Perio Aid		Disclosing Solution		
12.	Are you being treated by a phy	sician at this time? yes n	o If so, why?			
3.	Do you consider your general h			Poor?		
	Your last physical evaluation w					
4.	Has your general health chang	ed within the last year? ye	es no Explain:			
5.	Are you taking any medication, drugs, or pills regularly? <b>yes no</b> If so, list name and amount of dosage:					
6.	List all childhood diseases:					
7.	Have you ever had, or do you h	ave now, any of the following	ng?			
	Anemia	High blood pressure	Lung trouble	Liver trouble _	Epilepsy	
	Blood disease	Low blood pressure	Asthma	Gland trouble	Skin disease	
	Bleeding problems _	Diabetes	Tuberculosis	Bladder trouble _	Thyroid disease	
	Clotting Problems	Venereal disease	Ulcer(s)	Psychiatric tmnt _	Malignancy	
	Heart disease	Hepatitis	Bowel disease	Glaucoma _	Radiation therapy	
	Stroke	Arthritis	Kidney trouble	Sinus trouble _	Drug or alcohol dep	
	Rheumatic fever	Rheumatism	HIV (AIDS)	Heart trouble		
	Women: Are you pre	egnant? <b>yes no</b> Whice	ch month?	Oral contraceptives	? yes no	
	Have you reached n	nenopause? yes no	Are you taking horn	nones? yes no		
8.	Have you ever taken anti-coag	ulants (blood thinners)? y	es no When and	for how long?		
9.	Do you have a family history of	diabetes? <b>yes no</b> W	/ho?			
0.	Have you recently noticed any	swollen glands in the neck	? yes no			
1.	Circle, or note, the drug(s) you	have reacted adversely to:				
	Penicillin Aspirin	Codeine	Novacaine Deme	erol Erythromycin	Other	
	Antihistamines Barbiturate	es Local Anesthetics	Darvon Antib	iotics Tetracycline		
2.	Have you had major surgery?	yes no When?	Any o	complications?		
	For what?					
3.	Do you take vitamins, mineral s	supplements? yes no				
4.	Please describe any current me	edical treatment, impendin	g operations, or any ot	her medical or dental info	ormation that may	
	possibly affect your periodonta	ıl care:				
_	Whom may we contact in case	of omorganov?		Phone:		
J.	Thom may we contact in case	or emergency:				
ig	nature of Patient or	Date	Signature	of Periodontist	Date	



**Practice Limited to Periodontics** 

## - FINANCIAL POLICY -

## ALL PATIENTS MUST COMPLETE OUR "PATIENT INFORMATION FORM" BEFORE SEEING DR. DENT

We are committed to providing you with the BEST possible care and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our FINANCIAL POLICY is important in our relationship with you. We will be happy to answer any questions to the best of our ability concerning fees and insurance.

<u>PAYMENTS ARE DUE AT THE TIME SERVICE IS PROVIDED.</u> WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS, AND CARE CREDIT. RETURNED CHECKS WILL BE SUBJECT TO ADDITIONAL FEES.

## **REGARDING INSURANCE:**

If you have insurance, we will file your insurance and help receive your maximum benefits. If your insurance company has not paid the FULL BALANCE within 45 days, you are responsible for the account balance. If they pay more than the balance due, we will issue a refund check to you immediately. You are responsible for the timely payment of your account regardless of insurance status.

Insurance is a contract between you and your insurance company. We are not a party to THAT contract. If we are a participating provider with your group plan, we will handle your claims according to the agreement with the insurance company, if one exists.

We file <u>PRIMARY</u> insurance as a courtesy to our patients. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, non-covered services, "usual and customary" charges, etc., other than to supply factual information necessary regarding treatment. Additionally, IF WE CHOOSE to file secondary insurance for you after the primary responds, it is our policy to use the primary insurance estimate when calculating your portion. <u>At the time of service, the patient would be responsible for portion after primary insurance only.</u> In some cases, secondary insurance considers what the primary pays to be proper compensation and benefits are not coordinated by them for payment.

## **MISSED APPOINTMENTS:**

Unless cancelled at least 24 hours in advance, our policy is to charge for broken/missed appointments at the rate of a normal office visit. Please help us serve you better by keeping your scheduled appointments.

Thank you for your understanding of our financial policy. Please let us k	know if you have any questions or concerns.					
* RESPONSIBLE PARTY SIGNATURE:	DATE:					
PAYMENT DUE AT TIME SERVICES ARE RENDERED						
NOTE IF DENTAL INSURANCE IS IN ANOTHER PERSON'S NA	ME, PLEASE GIVE INFORMATION.					
Name of Person:						
Place of Employment:						
Date of Birth:						
Social Security #						