PATIENT INFORMATION HEALTH QUESTIONNAIRE

Date: _____ Soc. Sec. No.: _____ Birthdate _____ Sex _____

Full Name | Hm. Ph.: | ~~Wk. Ph.~~ Cell

Mailing Address | City, State, Zip Code

Occupation & Employer | Address

Spouse's Name | Spouse's Business Phone

Spouse's Employer | Address

Physician's Name | Whom may we thank for referring you to our office?

Dentist's Name

PRIMARY 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 EXAMINATION AND HEALTH HISTORY QUESTIONAIRE

In order to evaluate your dental health thoroughly and completely, please complete the following examination questionnaire. This will become part of your office record and will be held in strict confidence.

1. Are you experiencing pain from your mouth at this time? **yes no** If so, please explain: _____
2. How many times have you had your teeth cleaned in the past 5 years? _____ When was the last time?_____
3. Have you had previous periodontal treatments? **yes no** Dentist _____ Date_____
4. Are your teeth sensitive to heat, cold, or sweets? **yes no** Which ones? _____
5. How often do you brush your teeth?_____ Floss your teeth? _____
6. Would you be tremendously disturbed if you had to lose all your teeth and wear false teeth? **yes no**
7. Are your satisfied with the appearance of your teeth? **yes no**
8. Do you smoke? **yes no** What and how much? _____
9. Are you fearful about undergoing periodontal therapy? **yes no**
10. Have you had an extremely frightening experience with dentistry? **yes no** Explain:_____

_____

Continued on reverse side.

11. Please indicate the items you regularly use to care for your mouth:

___ Hand Toothbrush	___ Rubber Stimulator	___ Stimudents	___ Other
___ Electric Toothbrush	___ Toothpicks	___ Water Spray	
___ Dental Floss	___ Perio Aid	___ Disclosing Solution	

12. Are you being treated by a physician at this time? **yes no** If so, why? _____

_____

13. Do you consider your general health to be good? _____ Fair? _____ Poor? _____

Your last physical evaluation was on? _____

14. Has your general health changed within the last year? **yes no** Explain: _____

_____

15. Are you taking any medication, drugs, or pills regularly? **yes no** If so, list name and amount of dosage: _____

_____

_____

_____

16. List all childhood diseases: _____

_____

17. Have you ever had, or do you have now, any of the following?

___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 pregnant? **yes no** Which month? _____ Oral contraceptives? **yes no**

Have you reached menopause? **yes no** Are you taking hormones? **yes no**

18. Have you ever taken anti-coagulants (blood thinners)? **yes no** When and for how long? _____

19. Do you have a family history of diabetes? **yes no** Who? _____

20. Have you recently noticed any swollen glands in the neck? **yes no**

21. Circle, or note, the drug(s) you have reacted adversely to:

Penicillin	Aspirin	Codeine	Novacaine	Demerol	Erythromycin	Other _____
Antihistamines	Barbiturates	Local Anesthetics	Darvon	Antibiotics	Tetracycline	_____

22. Have you had major surgery? **yes no** When? _____ Any complications? _____

For what? _____

23. Do you take vitamins, mineral supplements? **yes no**

24. Please describe any current medical treatment, impending operations, or any other medical or dental information that may possibly affect your periodontal care: _____

_____

_____

25. Whom may we contact in case of emergency? _____ Phone: _____

_____ _____

Signature of Patient or Parent, if minor — Date

Signature of Periodontist JEFFREY J. DENT, D.D.S. — Date

JEFFREY J. DENT, D.D.S.

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.

PAYMENTS ARE DUE AT THE TIME SERVICE IS PROVIDED. 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 PRIMARY 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. **At the time of service, the patient would be responsible for portion after primary insurance only.** 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 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 NAME, PLEASE GIVE INFORMATION.

Name of Person: _____

Place of Employment: _____

Date of Birth: _____

Social Security #: _____