

WELCOME TO THE OFFICE OF DRS. HESS, DAVIS AND DEFINA

CONFIDENTIAL

PLEASE PRINT

Patient Name, Street Address, City, State, Zip, SS#, Birthdate, Height, Weight, Home Phone, Work Phone, E-mail Address, Cell Phone, Employer, Occupation, Spouse's Name, Spouse's Birthdate, Spouse's SS#, Do you have dental insurance?, Primary dental insurance name/address, Secondary dental insurance name/address, Medical insurance name/address, Person to contact if you are not available, Referred by, Dentist, Phone

MEDICAL HISTORY

Physician Name, Phone

Have you ever had any of the following? (check boxes that apply)

- Heart Problems, Heart Murmur, Artificial Joint, Rheumatic Fever, High Blood Pressure, Prolonged Bleeding, Low Blood Pressure, Diabetes, Hepatitis, Emphysema, Liver Problems, Tuberculosis, Kidney/Bladder Problems, Asthma/Hay Fever, Glaucoma, Anemia, Ulcer/Colitis, Thyroid Problems, AIDS/HIV, Epilepsy, Cancer (type), Heart Valve (artificial), Seizures

How would you describe your general health? Excellent Good Fair Poor

Have you been under a physician's care in the last year? Yes No

If yes why?

Have you been hospitalized in the last 5 years? Yes No

List ALL medications you are taking:

Do you take anticoagulants (blood thinners)? Yes No

Do you take aspirin on a daily basis? If yes how many? Yes No

Do you take or have you taken oral or I.V. bisphosphonates (Fosamax, Actonel, Boniva, etc.)? Yes No

Do you take or have you taken cortisone (steroids)?

List any medications you are allergic to:

Do you smoke or use tobacco in any form? Yes No

Do you consume alcohol on a regular basis? Yes No

Do you have any sensitivity to latex or latex products? Yes No

Have you been told by a physician to take antibiotics before dental treatment? Yes No

If yes have you taken them today? Yes No

FEMALES ONLY: Are you pregnant? Yes No # of months

Are you taking birth control pills? Yes No

Have you been through menopause? Yes No

***Do you have any disease, condition, or problems not listed above that you believe would affect treatment in any way?

Comments:

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance with _____
(Name of insurance company (ies))

and assign directly to Periodontal Associates, Inc. all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions whether manual or electronic.

DATE _____ SIGNATURE _____

FINANCIAL AGREEMENT

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents/guardians are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges not covered by insurance.

DATE _____ SIGNATURE _____

INFORMED CONSENT

All the risks, complications, prognosis, treatment and alternatives have been explained to me. I have had the opportunity to ask any questions relative to the recommended treatment. I agree to accept the proposed treatment as outlined.

Signed: Patient, Parent or Guardian _____ Date _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

Please Print Name

Signature

Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
 - Communication barriers prohibited obtaining the acknowledgment
 - An emergency situation prevented us from obtaining acknowledgement
 - Other (Please Specify)
- _____

