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

CONFIDENTIAL

PLEASE PRINT

Patient Name ______________________ SS# ______________ Birthdate ______________

Street Address ______________________ City ______________ State __________ Zip ________

☐ M ☐ F ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Height: ____________ Weight: ________ Home Phone ______________ Work Phone ______________

E-mail Address ______________________ Cell Phone ______________________

Employer ______________________ Occupation ______________________

Spouse's Name ______________________ Spouse's Birthdate ______________________

Employer ______________________ Spouse's SS# ______________________

Do you have dental insurance? ☐ Yes ☐ No ID # ______________ Group # ______________

Primary dental insurance name/address ______________________

Secondary dental insurance name/address ______________________

Medical insurance name/address ______________________

Person to contact if you are not available ______________________ Phone ______________

Referred by ______________________ Dentist ______________ Phone ______________

MEDICAL HISTORY

Physician Name ______________ Hospital ______________ Phone ______________

Please check any illnesses or conditions you have EVER had:

☐ Anemia or blood problems	☐ Bleeding Disorders	☐ Drug/Alcohol Abuse	☐ HIV/AIDS
☐ Any Heart Problem	☐ Epilepsy/Seizures	☐ Kidney/Bladder problems	
☐ High Blood Pressure	☐ Emphysema	☐ Glaucoma	☐ Thyroid Problems
☐ Diabetes: Last A1c: ________	☐ Artificial Heart Valve	☐ Liver problems	☐ Tuberculosis
A1c: ______ When? ______	☐ Asthma	☐ Ulcer/Colitis	☐ Hepatitis A, B, C
A1c: ______ When? ______	☐ Stroke When? ______	☐ Cancer Type: ______	☐ Chemo Schedule: ______

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

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

Has a physician given you antibiotics before dental visits to prevent heart/joint infections? .... ☐ Yes.......☐ No

If yes, did you take them today?.................................... ☐ Yes.......☐ No

JOINT REPLACEMENT

Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?.................... ☐ Yes.......☐ No

Date: ____________ If yes, have you had any complications? ______________________

MEDICATIONS

Do you take blood thinners? (Coumadin/Warfarin, Pradaxa, Xarelto, Eliquis) INR Value and Date ________ .... ☐ Yes.......☐ No

Do you take Aspirin on a daily basis? If yes, what dosage? ________.................... ☐ Yes.......☐ No

Have you ever taken drugs by mouth or by injection to strengthen bone for conditions such as osteoporosis, multiple myeloma, Paget's disease, breast, prostate or metastatic cancer?.................... ☐ Yes.......☐ No

(i.e. Fosamax, Actonel, Boniva, Reclast, Prolia, Aredia, Zometa, or Xgeva)

If yes, how long have you been taking this? ______________ If no longer, when did you stop? ______________

List ALL Medications you are taking: ______________________

____

ALLERGIES

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

List ALL medications you are allergic to: ______________________

____

Do you smoke or use tobacco in any form? # Packs/day ______ # years using ______ .... ☐ Yes.......☐ No

FEMALES ONLY: Are you pregnant.......☐ Yes.......☐ No Are you taking birth control pills?.................... ☐ Yes.......☐ No

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

____

____

OVER PLEASE

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

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)

____

____

____