Periodontal Associates, Inc.

WELCOME TO THE OFFICE OF

Dr. Roger Hess • Dr. Rebecca Davis • Dr. Jason Streem

SPECIALISTS IN PERIODONTOLOGY • IMPLANTOLOGY

CONFIDENTIAL

Patient Name:_____

(Please circle one) Mr. Mrs. Miss Ms. Dr. SS#_____**DOB**_____

Address_____**City**_____

State_____**Zip**_____ **Home Phone**_____**Cell Phone**_____**Work Phone**_____

Email_____ ○ **Male** ○ **Female** ○ **Other** ○ **Single** ○ **Married** ○ **Divorced** ○ **Widowed**

EMERGENCY CONTACT NAME_____**PHONE**_____

GENERAL DENTIST NAME/Referred by_____

PHONE_____ ***ADDRESS*** _____

Employer_____**Occupation**_____

Spouse_____**DOB**_____**SS#**_____

Employer_____**Occupation**_____

DENTAL INSURANCE PRIMARY_____**Sub. ID#**_____

Primary Address_____**Grp#**_____

DENTAL INSURANCE SECONDARY_____**Sub. ID#**_____

Secondary Address_____**Grp#**_____

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.

SIGNATURE_____**DATE**_____

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 or child. I accept full financial responsibility for all charges not covered by insurance.

SIGNATURE_____**DATE**_____ ___

ACKNOWLEDGMENT AND RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____have received a copy of this office's NOTICE OF PRIVACY PRACTICES.
(Patient, Parent or Guardian)

PRINT_____

SIGNATURE_____

DATE_____

If you have a health history on file with us, and it is not more than 1 year old, ***and you have had NO CHANGES in your Health History (Including medications), your address and contact information or your insurance information, please sign below.***

Patient Signature_____**Date**_____

PLEASE TURN THIS PAGE OVER AND COMPLETE THE OTHER SIDE!!

MEDICAL HISTORY

Physicians Name_____**Hospital**_____**Phone**_____

How would your rate your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Have you been hospitalized in the last 5 years? _____ ☐ **YES** ☐ **NO**

If yes please explain:_____

PLEASE CHECK ANY ILLNESSES/CONDITIONS YOU HAVE EVER HAD:

Anemia or blood problems ☐ Bleeding Disorders ☐ Drug or Alcohol Abuse ☐ HIV/AIDS ☐ Heart Problems ☐

Heart Valve ☐ Epilepsy/Seizures ☐ Kidney/Bladder Problems ☐ High Blood Pressure ☐ Emphysema/COPD ☐ Glaucoma ☐

Thyroid ☐ Diabetes: ☐ Last A1C_____ When?_____ Liver Problems ☐ Tuberculosis ☐ Asthma ☐ Ulcer/Colitis ☐

Hepatitis A, B, C ☐ Stroke: ☐ When?_____ **Cancer:** ☐ **Type:**_____**Chemo Schedule**_____

ARE YOU TAKING ANY MEDICATIONS? _____ ☐ **YES** ☐ **NO**

IF YES PLEASE LIST ALL MEDICATIONS*:*_____

_____

NAME AND CITY OF YOUR PHARMACY_____

Do you take BLOOD THINNERS?_____ **INR Value and Date**_____ ☐ **YES** ☐ **NO**

(EXAMPLES: Coumadin, Warfarin, Pradaxa, Xarelto, Eliquis)

Do you take a daily ASPIRIN? If so what dosage?_____ ☐ **YES** ☐ **NO**

JOINT REPLACEMENT:

Have you had orthopedic total joint replacement? (Hip, Knee, Shoulder, Elbow, Finger)_____ ☐ **YES** ☐ **NO**

Date of Surgery:_____**If yes, have you had any complications?**_____

***PREMEDICATION*:**

DO YOU TAKE antibiotics before dental visits to prevent heart/joint infections?_____ ☐ **YES** ☐ **NO**

Have you ever taken drugs by mouth or injection to strengthen bone for conditions such as Osteoporosis, Multiple Myeloma, Paget's Disease, Breast, Prostate or Metastatic Cancer?

_____ ☐ **YES** ☐ **NO**

(EXAMPLE: 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?**_____

DO YOU HAVE ANY KNOWN ALLERGIES: _____ ☐ **YES** ☐ **NO**

IF YES PLEASE LIST:_____

_____

Do you have any sensitivity to Latex or Latex products? _____ ☐ **YES** ☐ **NO**

Do you smoke or use tobacco in any form?_____**Packs per Day?**_____**Years of Use?**_____ ☐ **YES** ☐ **NO**

DO YOU HAVE ANY DISEASE, CONDITION, OR PROBLEMS NOT LISTED THAT YOU BELIEVE WOULD AFFECT YOUR TREATMENT IN ANY WAY?_____ ☐ **YES** ☐ **NO**

If yes please explain:_____

FEMALES ONLY:

Are you pregnant?_____ _____ ☐ **YES** ☐ **NO**

Are you taking birth control pills?_____ ☐ **YES** ☐ **NO**