



SOUTH BAY PERIODONTICS

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions we will be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Name _____ Soc. Sec. #: _____
 Last First M.I. City State Zip
 Address _____
 Home phone _____ Cell phone _____ Email address _____
 Sex M F _____ Age _____ Birth date _____
 Patient Employed by _____ Occupation _____
 Business address _____ Business phone _____
 Whom may we thank for referring you to us today? _____
 Notify in case of an emergency _____ Home phone _____ Other# _____

Primary Dental Insurance

Policy holder _____ S.S.N. _____ D.O.B. _____ Relation _____
 Last First M.I.
 Employer _____
 Insurance Company _____ Phone _____
 Insurance Co. address _____ State _____ Zip _____ Group# _____
 %preventative %Basic %Major %Perio %Implants Eff. Date _____ UTD _____
 Yearly Maximum _____

Secondary Dental Insurance

Policy holder _____ S.S.N. _____ D.O.B. _____ Relation _____
 Last First M.I.
 Employer _____
 Insurance Company _____ Phone _____
 Insurance Co. address _____ State _____ Zip _____ Group # _____
 %preventative %Basic %Major %Perio %Implants Eff. Date _____ UTD _____
 Yearly Maximum _____

Authorization

I authorize the insurance company indicated on this form to pay the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____
(Payment is due in full at time of treatment unless prior arrangements have been approved.)

Dental History

What is your chief concern? _____

How long since your last exam/cleaning? _____

Have you ever had a deep dental cleaning with anesthetic (root planing)? _____ How long ago? _____

Have you ever had periodontal surgery? _____ How long ago? _____

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? Y N _____

Medical Information

Physician's name _____ Phone # _____ Date of last visit _____

Are you currently under a physician's care? Y N If yes, describe _____

Are there any other health conditions we should be aware of? _____

Preferred Pharmacy _____

Do you currently smoke? Y N Do you have a history of smoking? Y N If yes, how much? _____ Number of years _____

Do you use Smokeless Tobacco? Y N

Do you drink? Y N If yes, how much? _____ How long? _____

Women: Are you pregnant? Y N Nursing? Y N Taking birth control pills? Y N Osteoporosis? Y N

Please indicate if you experience any of the following:

- Cardiovascular disease
- Heart attack
- Blood pressure problems
- Heart murmur
- Rheumatic fever
- Pacemaker
- Stroke
- HIV/Aids
- Radiation/Chemotherapy
- Abnormal bleeding
- Asthma
- Sleep Apnea
- Cancer/Tumor
- Joint replacement
- Diabetes, Last A1C level _____

HISTORY OF:

- Hepatitis; Jaundice
- Liver disease
- Kidney disease
- Tuberculosis
- Glaucoma
- Seizures or Epilepsy
- Substance abuse

Are you allergic to or have you reacted adversely to:

- local anesthetics
- Penicillin, other antibiotics
- Sulfa drugs
- Sedatives
- Aspirin
- Codeine
- Latex
- Other _____

During the past 12 months have you taken:

- Anticoagulants (Coumadin, Plavix, etc.)
- High blood pressure medication
- Insulin, Metformin, etc
- Aspirin
- Nitroglycerin
- Cortisone (steroids)
- Fosamax
- Other _____

Do you take aspirin? Y or N
Can you take ibuprofen (Advil)? Y or N

List all current medications:

What is your estimate of your general health?

___Excellent ___Good ___Fair ___Poor

Do you take daily fish oil? Y or N

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

Patient Signature _____ Date _____

Doctor Signature _____ Date _____