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.
Address____City___________________State________Zip__________

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.)

SOUTH BAY PERIODONTICS

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 _______
__ High Cholesterol
__Hypo/Hyperthyroidism

HISTORY OF:
__ Hepatitis; Jaundice
__ Liver disease
__ Seizures or Epilepsy
__ Kidney disease
__ Tuberculosis
__ Glaucoma
__ Substance abuse
__ Cold Sores

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
__ Nitroglycerin
__ Dexamethasone
__ Cortisone (steroids)
__ Fosamax
__ Dexamethasone
__ Other__________________

Do you take daily 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____________________