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_____ SSN_____ DOB_____ 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
&
IMPLANT DENTISTRY

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
__ Seizures or Epilepsy
__ Kidney disease
__ Tuberculosis
__ Glaucoma
__ 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
__ Dexamethasone
__ 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 dental treatment. If there is any change in my medical status, I will inform the dentist.

Patient Signature_____ Date_____

Doctor Signature_____ Date_____