Welcome to PerioCare

PATIENT INFORMATION...

Date ____________

❏ Mr. ❏ Mrs. ❏ Ms. ❏ Dr. First Name ____________ M.I. ____ Last Name ____________

Nickname ____________ Sex: ❏ Male ❏ Female Birth Date ____________ Age ____ Soc. Sec. # ____________

Street ____________ Apt. ____ City ____________ State ______ Zip ______

Home Tel.(____) ____________ Cell.(____) ____________ Work (____) ____________

E-mail ____________

Student: .... ❏ Full Time ❏ Part Time

Marital Status: .... ❏ Married ❏ Divorced ❏ Widow ❏ Single

Employed: .... ❏ Full Time ❏ Part Time ❏ Retired ❏ Not

Preferred Pharmacy ____________ Tel.(____) ____________

Have you ever been a patient of our practice? ❏ Yes ❏ No

Emergency contact ____________ (FIRST NAME) ____________ (LAST NAME) Tel. (____) ____________ Relation ____________

WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT...

❏ Self (If self, skip this section) ❏ Spouse ❏ Father ❏ Mother ❏ Other ____________

Name ____________ (FIRST NAME) ____________ (LAST NAME) S.S.# ____________ Birth Date ____________ Age ____ Tel.(____) ____________

Street ____________ Apt. ____ City ____________ State ______ Zip ______

Driver's Lic.# ____________ Employer ____________ Bus. Tel.(____) ____________

SPOUSE OR OTHER GUARANTOR INFORMATION (if different from above)...

Name ____________ (FIRST NAME) ____________ (LAST NAME) Relation ____________ S.S.# ____________ Birth Date ____________

Street ____________ Apt. ____ City ____________ State ______ Zip ______

Tel. (____) ____________ Employer ____________ Bus. Tel.(____) ____________

DENTIST / MEDICAL DOCTOR...

Dentist ____________ (FIRST NAME) ____________ (LAST NAME)

Medical Doctor ____________ (FIRST NAME) ____________ (LAST NAME)

PRIMARY DENTAL INSURANCE CO...

Please bring a copy of your dental insurance card to your appointment.

Employer ____________

Employee's Name ____________ ____________

Relation ____________

Birth Date ____________ S.S. # ____________

Employee's Address ____________

City ____________ State ______ Zip ______

Employee's Tel.(____) ____________

Ins. Co. Name ____________

I.D. # ____________ Group # ____________

SECONDARY DENTAL INSURANCE CO...

Please bring a copy of your dental insurance card to your appointment.

Employer ____________

Employee's Name ____________ ____________

Relation ____________

Birth Date ____________ S.S. # ____________

Employee's Address ____________

City ____________ State ______ Zip ______

Employee's Tel.(____) ____________

Ins. Co. Name ____________

I.D. # ____________ Group # ____________

DENTAL INFORMATION...

Reason for today's visit ____________

____

Are you in pain? ❏ Yes ❏ No, For How Long? ____________

Trouble associated with previous dental treatment ____________

____

____

Is there any other dental information we should know about ____________

____

____

Patient Name ______________________

MEDICAL HISTORY...

Height ____________ Weight ____________

Are you under the care of a physician? ❏ Yes ❏ No; if Yes, explain ______________________

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ❏ Yes ❏ No

Have you had any illness, operation, or been hospitalized in the past five years? ❏ Yes ❏ No

Have you ever had conscious sedation? ❏ Yes ❏ No • Have you, or a family member, had any unusual or serious reactions to conscious sedation? ❏ Yes ❏ No

Do you have, or have you had, any of the following diseases, medical conditions, or procedures?

Y N
- ❏ ❏ Do you smoke or vape
  If so, how much a day ________
- ❏ ❏ Do you use chewing tobacco
- ❏ ❏ High blood pressure
- ❏ ❏ Low blood pressure
- ❏ ❏ Mitral valve prolapse
- ❏ ❏ Heart murmur
- ❏ ❏ Rheumatic fever
- ❏ ❏ Chest pain / Angina
- ❏ ❏ Heart attack(s)
- ❏ ❏ Irregular heart beat
- ❏ ❏ Cardiac pacemaker
- ❏ ❏ Heart surgery
- ❏ ❏ Damaged heart valves
- ❏ ❏ Pneumonia / Bronchitis / Chronic cough
- ❏ ❏ Chronic fatigue / Night sweat

Y N
- ❏ ❏ Trouble climbing 1-2 flights of stairs
- ❏ ❏ Anemia
- ❏ ❏ Asthma
- ❏ ❏ Mental health problems
- ❏ ❏ Problems with immune system *(possibly from med. / surg.)*
- ❏ ❏ Delay in healing
- ❏ ❏ Hay fever / Sinus problems
- ❏ ❏ Snoring
- ❏ ❏ Sleep apnea / CPAP
- ❏ ❏ Respiratory problems
- ❏ ❏ Tuberculosis
- ❏ ❏ Emphysema
- ❏ ❏ A history of marijuana or other drug use
- ❏ ❏ A history of alcohol abuse

Y N
- ❏ ❏ Abnormal bleeding
- ❏ ❏ Bleeding tendency
- ❏ ❏ Blood transfusion
- ❏ ❏ Blood disorder
- ❏ ❏ Bruise easily
- ❏ ❏ Eye disease / Glaucoma
- ❏ ❏ Jaundice / Liver disease
- ❏ ❏ Hepatitis
- ❏ ❏ Gallbladder trouble
- ❏ ❏ Fainting spells
- ❏ ❏ Convulsions / Epilepsy
- ❏ ❏ Stroke
- ❏ ❏ Thyroid trouble
- ❏ ❏ Diabetes
- ❏ ❏ Low blood sugar
- ❏ ❏ Are you on dialysis

Y N
- ❏ ❏ Kidney trouble
- ❏ ❏ Sexually transmitted diseases
- ❏ ❏ COVID–19
- ❏ ❏ Contagious diseases
- ❏ ❏ Infectious mononucleosis
- ❏ ❏ Swollen ankles
- ❏ ❏ Arthritis / Joint disease
- ❏ ❏ Prosthetic implant
- ❏ ❏ Joint replacement
- ❏ ❏ Osteoporosis / Osteopenia
- ❏ ❏ Osteonecrosis
- ❏ ❏ Stomach ulcers / acid reflux
- ❏ ❏ Tumor or growth
- ❏ ❏ Cancer / Radiation / Chemotherapy
- ❏ ❏ Are you on a diet
- ❏ ❏ Contact lenses

MEDICATION...

Are you now taking:

Y N
- ❏ ❏ Nerve pills
- ❏ ❏ Diet pills

Y N
- ❏ ❏ Pain killers (including aspirin)
- ❏ ❏ Tranquilizers

Y N
- ❏ ❏ Muscle relaxers
- ❏ ❏ Insulin

Y N
- ❏ ❏ Stimulants
- ❏ ❏ Antidepressants
- ❏ ❏ Blood thinners (Coumadin, Aspirin, Eliquis, Xarelto)
- ❏ ❏ Are you taking, or have you ever taken bone density meds, RANKL inhibitors or bisphosphonates such as Denosumab, Fosamax, Boniva, Actonel, IV-Zometa, Aredia, Reclast, Prolia, Xgeva, or Evista in the past 12 years?

Please list any other medication(s) you are taking (including natural, herbal, or homeopathic products):

MEDICATION	DOSAGE	FREQUENCY	MEDICATION	DOSAGE	FREQUENCY

ALLERGIES...

Are you allergic to, or had a reaction to:

Y N
- ❏ ❏ Penicillin
- ❏ ❏ Sodium pentothal / Valium / other tranq.
- ❏ ❏ Soy

Y N
- ❏ ❏ Sulfa drugs
- ❏ ❏ Aspirin
- ❏ ❏ Eggs / Yolk

Y N
- ❏ ❏ Local anesthetic (numbing med)
- ❏ ❏ Codeine or other narcotics
- ❏ ❏ Sulfites

Y N
- ❏ ❏ Amoxicillin
- ❏ ❏ Latex
- ❏ ❏ Do you have any known allergies

Please list any other medication or antibiotic you are allergic to:

MEDICATION / ANTIBIOTIC NAME	MEDICATION / ANTIBIOTIC NAME

Please list any allergies other than drug allergies:

____

____

____

____

WOMEN ONLY...

1-4 below for women only: *(Women note: antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician / gynecologist for assistance regarding additional methods of birth control.)*

1) Is there a possibility of pregnancy? ❏ Yes ❏ No

2) Expected delivery date: ______________________

3) Are you nursing? ❏ Yes ❏ No

4) Are you taking birth control pills: ❏ Yes ❏ No

Patient Name ______________________________

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his / her staff, responsible for any errors or omissions that I have made in the completion of this form.

❏ I permit the office to communicate with me via text message on my cell phone.

X ______________________ **X** ______________________ **X** ______________

Signature of patient *(Parent or Guardian if Minor)* **Reviewed by** **Date**

FEES & PAYMENTS

We make every effort to keep down the cost of your care. You can help by paying upon completion of each visit. Other arrangements can be made with our office manager depending upon special circumstances. An estimate of the charge for any procedure or surgery you may require will be given to you upon request. If you have any dental and/or medical insurance we will be glad to fill out the proper forms, but please complete the identifying information on this form.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company.** You will be responsible for all collection costs, attorneys fees, and court costs.

X ______________________________________ **X** ______________

Signature of patient *(Parent or Guardian if Minor)* **Date**

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

X ______________________________________ **X** ______________

Signature of patient: *(Parent or Guardian if Minor)* **Date**

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

X ______________________________________ **X** ______________

Signature of patient *(Parent or Guardian if Minor)* **Date**

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

With our permission, we may disclose your Protected Health Information to a family member, relative, close friend or any other person you identify that is directly involved in your health care.

I, ______________________________, authorize PerioCare to release any personal information relating to my health care.

To ______________________________ Relationship to Patient ______________________________

To ______________________________ Relationship to Patient ______________________________

I understand I have the right to restrict information that may be released and that this restriction must be in writing.

❏ No Restrictions

❏ With Restrictions *(please list)* ______________________________

X ______________________________________ **X** ______________

Printed name **Date**

X ______________________________________

Signature of patient

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