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| Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Birthdate\_\_\_\_\_\_\_\_\_\_SS#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Home Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_cell phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_work phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Mailing address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_Zip\_\_\_\_\_Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Marital status\_\_\_\_\_\_\_\_\_\_\_\_\_ Age\_\_\_\_\_\_Referring Doctor\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Physician’s name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Billing Information:** Dental insurance company\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Covered by spouse’s insurance? □yes □no  If yes,companyname\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Spouse’sname\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Medical Health History**

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| **Check all that apply**□ Cancer□ Heart ailment or angina□ Heart murmur, mitral valve prolapse, defect□ Rheumatic fever or rheumatic heart disease□ Artificial joint or valve□ High or low blood pressure□ Pacemaker□ Tuberculosis or lung problems□ Kidney disease□ Hepatitis or liver problems□ Blood transfusion□ Diabetes□ Neurologic conditions□ Stroke□ Epilepsy,seizures,fainting□ Arthritis□ AIDS or HIV positive□ Migraine headaches, frequent headaches□ Anemia or blood disorders□ Abnormal bleeding after extractions or surgery□ Allergies or hives□ Asthma□ Cold sores or fever blistersDo you smoke or use tobacco products? □ yes □ no | Are you allergic to, or have you reacted adversely to any of the following? □ Latex materials □ Penicillin  □ other antibiotics\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Local anesthetics (“Novocain”) □ Codeine or narcotics □ Sulfa drugs □ Barbiturates, sedatives, sleeping pills □ Aspirin □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Are you taking any of the following? □ Aspirin □ Anticoagulants (blood thinners) □ High Blood pressure medication □ Antidepressants or tranquilizers □ Insulin, Orinase, other diabetes meds □ Nitroglycerin □ Cortisone or other steroids □ Osteoporosis medicine □ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Women:**  □ may be pregnant?  □ Taking hormones or contraceptives |
|  |  |

**Do you have any diseases or problems not listed above**? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Consent for Treatment**

I the undersigned, affirm that the information above is accurate and complete to the best of my knowledge. I will not hold my periodontist or any member of the staff responsible for errors or omissions that I made in the completion of this form. I consent to any advisable and necessary periodontal therapy to be administered by the periodontist or his staff.I agree to the use of local anesthetics and other medications as necessary. I fully understand that the use of local anesthetic agents embodies risks. I authorize the periodontist to release any information including the diagnosis and records of treatment or examination of me or my child during the period or treatment to third party payers and or health practitioners. I authorize and request the insurance company to pay directly to the periodontist. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment for all services rendered on behalf of me or my dependents. I understand that interest may be added to accounts not paid by agreed upon dates (18%APR).

**Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**