DENTAL/MEDICAL HISTORY

Present Problem_____

_____

Past Dental Care Dr._____**How Long**_____

Last X-Rays_____ **Last Cleaning?**_____

Toothbrush Type_____**Frequency**_____**X/Day-Other aids**_____

Bleeding Gums_____**Recession**_____**Past Perio/Ortho**_____

How do You feel about Your teeth?_____

Physician's Name:_____Phone #:( )_____Date of last visit:_____
Do you smoke or use tobacco in any other form? YES NO
For Women: Are you Pregnant? YES NO Are you nursing? YES NO Are you taking birth control pills? YES NO
Have you ever been advised by a physician that you should premedicate with antibiotics for dental treatment? YES NO

Have you ever or do you now have any of the following medical conditions? Please circle. (Y=Yes, N=No)

Y N Abnormal Bleeding
Y N Anemia
Y N Sickle Cell Disease/Traits
Y N Hemophilia Type?_____
Y N Blood Transfusion
Y N Gastric Ulcers
Y N Arthritis
Y N Osteoporosis
Y N Artificial Joints When?_____
Y N Cancer/Chemotherapy
Y N Radiation Treatment
Y N TMJ/TMD
Y N Frequent Headaches/Migraines
Y N Epilepsy / Fainting Spells
Y N Seizures Last/Type? _____
Y N Thyroid Problem

Y N Heart Disease
Y N High Blood Pressure
Y N Low Blood Pressure
Y N High Cholesterol
Y N Stroke When?_____
Y N Heart Attack When?_____
Y N Heart Surgery When?_____
Y N Cardiac Stent When?_____
Y N Pacemaker When?_____
Y N Heart Murmur
Y N Congenital Heart Disease / Prosthetic Cardiac Valve/ Previous Infective Endocarditis/ Palliative Shunt or Conduit

Y N Bisphosphonate use? Oral or IV? (e.g. Fosomax, Actonel, Boniva, Zometa)
Y N Alcohol/Drug Abuse
Y N Hepatitis Type? _____
Y N HIV / AIDS
Y N Tuberculosis (TB)
Y N Herpes/Fever Blisters/Cold sores
Y N Kidney Problems/Disease
Y N Liver Disease
Y N Psychiatric Problem(ie. depression)
Y N Diabetes
Y N Insulin Dependent
Y N Difficulty Breathing
Y N Asthma
Y N Emphysema

Any other medical condition(s)? YES NO If yes, please explain:_____

_____

Any prescription, over-the-counter, herbal or natural supplements? YES NO If yes, please list:_____

_____

Do you have any allergies to medications? YES NO If yes, please circle:

Penicillin	Codeine	Metals	Keflex	Levaquin	Tylenol
Latex	Erythromycin	Tetracycline	Doxycycline	Motrin/Advil (ibuprofen)	
Dental Anesthetics	Epinephrine	Clindamycin	Iodine	Z-Pack (azithromycin)	

Please list any other drugs/materials to which you are allergic: _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform my provider of any changes in my medical status.

Patient/Guardian Signature:_____ Date:_____

For office use only:
Date: _____ Initials: _____ Comments: _____
Date: _____ Initials: _____ Comments: _____
Date: _____ Initials: _____ Comments: _____

PERIODONTAL ASSOCIATES

Dr. Howard S. Levinbook, Dr. Jeffrey D. Goldschmidt

Patient Information

Patient Name: _____ ☐ Male ☐ Female Date:_____
Last, First MI (Preferred Name)

Social Security #: _____ Birth Date: _____ Family Status: _____

Phone# (Home): _____ (Work#): _____ Ext: _____ Cell#:_____

Email:_____

Address: _____
Street Apartment #

_____
City State Zip Code

In Case of Emergency contact:_____ **At phone #**_____

General Dentist:_____ **Last Visit**:_____

Physician: _____

☐ Spouse or ☐ Responsible Party Information (choose one)

Name: _____ ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____ ☐ Male ☐ Female

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Dental Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

PERIODONTAL ASSOCIATES

Dr. Howard S. Levinbook Dr. Jeffrey D. Goldschmidt

IMPORTANT NOTICE

Due to FEDERAL MANDATES called *Health Insurance Portability and Accountability Act, or HIPAA*, healthcare providers are now required to obtain patient consent for the release of private health information.

I give **Periodontal Associates** consent to release private health insurance information for the benefit of my continued quality healthcare. Healthcare information may be released to my primary care physician, referring dentist, insurance company, claim administrator, or consulting health care professional. For this purpose, private health information is defined as personal information, examination findings and/or treatment that is either proposed, underway or completed. This information may be used by an insurance company for the purpose of evaluating and administering claims for benefits.

_____
initial

I also give **Periodontal Associates** permission to leave appointment reminders and/or other pertinent messages on my answering machine, e-mail or at my place of employment, per my request, and/or to contact me by postcard or letter.

_____
initial

I understand that any information that has already been disclosed was not protected by this document. I also understand that I may revoke this authorization, in writing, at any time. **I have read this *Notice of Privacy Practices.***

_____ _____
signature date

Our Financial Policy

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. Please be aware that you are ultimately responsible for payment.

WE ACCEPT CASH,CHECKS,VISA/MASTERCARD,DISCOVER AND AMERICAN EXPRESS. IN ADDITION WE OFFER **CARE CREDIT**, AN INDEPENDENT COMPANY OFFERING LONG TERM DENTAL FINANCING-OFTEN WITHOUT INTEREST.

If you have Dental Insurance:
We accept assignment of your insurance benefits in most cases. **We do require your estimated co-payment to be paid at the time of service**. Since we cannot predict your insurance portion exactly, any balance remaining after the insurance will be your responsibility. We will help in estimating your portion by calling and/or filling out and sending forms to your insurance .You must understand, however, that your policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company has not paid their portion within 90 days, we will request and expect that the balance be paid by you. Please be aware that in some cases, services provided may be considered as "*non-covered*" or above your company's "*reasonable and customary*."

Missed Appointments:
Unless we are given at least 24 business hours notice, our policy is to charge for missed appointments. Please help us to serve you and our other patients by keeping your scheduled appointment.

Interest/Unpaid Balances:
We reserve the right to charge interest in the amount of 1.5% per month (18% per year) on any balances over 90 days unless prior arrangements, in writing, have been made. The patient is responsible for the cost of collection and/or reasonable attorney fees on unpaid balances.

Thank you for understanding our Financial Policy. Everyone benefits when definite financial arrangements are agreed upon in advance. Please let us know if you have any questions or concerns.

_____

Patient signature (or legal guardian)