PERSONAL INFORMATION Exam Date_____

Patient Name_____ Date of Birth _____-_____-_____
First MI Last

Home Address_____
(post office box not allowed) Street City State Zip

Home Phone (_____)_____ Other (_____)_____ Work Phone (_____)_____

E-mail address (if you want us to confirm appointments via e-mail _____

Employer:_____ May we reach you at the work phone Yes No

Social Security Number _____-_____-_____ Age_____ Sex_____

Emergency Contact: _____
Name Relationship Phone

Complete this section if patient is under age 19 (a minor). As the accompanying adult, you are financially responsible.

_____
Your name Relationship to patient Your social security number

_____
Address (if different from minor) City, State Zip Phone

_____
Your employer Address Phone

REFERRAL INFORMATION

Referring Dentist: _____
Name Address Phone

Other dental care provider_____
Name Address Phone

If referred by someone other than your dentist, please list _____
Name Relationship

INSURANCE INFORMATION

Primary dental insurance thru _____
Relationship to patient_____
Policy Holder Social Security # _____
Insurance Policy Number _____

Name of Policy Holder_____
Policy Holder Date of Birth_____
Employer _____
Group # _____

Secondary dental insurance thru _____
Relationship to patient_____
Policy Holder Social Security # _____
Insurance Policy Number _____

Name of Policy Holder_____
Policy Holder Date of Birth_____
Employer _____
Group # _____

Are you presently on Welfare or A.D.C.? ___No ___Yes

PLEASE NOTE: We do **NOT** participate in Medicare or Medicaid and are not preferred providers on any insurance plan. We will **NOT** file military-sponsored plans such as Delta or Tri-Care due to their provisions. We will, however, file claims with all other insurance and work to help you obtain your allowed dental/health care benefit for services provided.

Before your appointment with us, please read and initial each of the policies marked below. This is policy information only and **does not commit you to receiving any treatment at this office**. Please bring this form with you to your appointment as it will become part of your dental record at our office.

- **FINANCIAL ARRANGEMENTS:** Once a treatment plan has been presented to you, our staff will discuss payment options with you and make every effort to help you obtain recommended treatment.
  _____Patient Initials

- **RECEIPT OF MEDICARE PRIVATE CONTRACT:**
  ____ I am NOT covered by Medicare. _____Patient Initials

  ____ I am covered by Medicare and have received a copy of the Medicare Private Contract executed by me.
  _____Patient Initials

- **RELEASE OF INFORMATION:** I authorize this office to release copies and information from my patient records as needed in regards to my periodontal treatment at Specialty Dental Care. This authorization applies to medical, dental and insurance providers. I also authorize this office to request records as needed to provide for my periodontal care. _____Patient initials

- In addition, I authorize this office to release information pertaining to my dental, medical, insurance and account history to the family member/friend listed below:

  Name & Relationship_____ _____ Patient Initials

  Name & Relationship_____ _____Patient Initials

- **PUBLICATION OF RECORDS:** I understand that my condition and/or treatment may be of some use for teaching purposes. I authorize the use of slides, x-rays, photos, or other materials related to my case that have been taken before, during or after treatment completion to be used for teaching and/or publication purposes. I understand that my identity will not be revealed in the use of said materials. _____Patient initials

- **RECEIPT OF NOTICE OF PRIVACY PRACTICES:** I received a copy of the Notice of Privacy Practices regarding how Specialty Dental Care, P.C. may use my health information. _____ Patient initials

Reviewed By _____ on _____
SDC Staff Member

HEALTH HISTORY for _____ Exam Date_____

Name of Physician: _____ Phone #_____ Address _____

Please list any other Health Care Provider & specialty: _____

Are you currently being treated by the physicians listed above? ___ No ___Yes, for _____

Are you sensitive or allergic to any medicines? ___No ___Yes, to_____

Local Pharmacy Name & Location _____ Phone Number_____

Medications	taken for	time of day taken	how often	prescribing doctor	dental office notes

Hospitalizations and/or surgeries:

Date	Reason

Have you ever had a blood transfusion? ___No ___Yes When?_____

Do you smoke? ____No ____Yes, ____ packs per day Do you chew tobacco? ____No Yes, _____ cans per day

How often do you consume alcohol? _____

Have you ever used Fosamax or another bone strengthening medication? ____No ____Yes, for _____ year

CIRCLE ANY OF THE CONDITIONS THAT YOU HAVE HAD:

AIDS, ARC or HIV	Epilepsy/Seizures	High cholesterol	Scarlet fever
Anemia	Family history of diabetes	Hives from _____	Seasonal allergies
Angina	Gag during dental care	Joint replacement in _____	Sleep apnea
Arthritis	Gall bladder disease	Kidney disease	Stroke
Asthma	Glaucoma	Low blood pressure	Thyroid disease
Bladder problems	Heart attack	Nervousness	Tuberculosis
Blood thinner, _____	Heart disease	Pacemaker	Ulcers
Cancer of _____	Heart murmur	Phen-Fen use in _____	Venereal disease
Claustrophobia	Heart surgery	Psychiatric care	X-ray treatment
Diabetes	Hepatitis, Type _____	Reflux disease	Other_____
Dizziness/Fainting	High blood pressure	Rheumatic fever	Other_____

Patient Signature_____ Date_____

Reviewed by pt on:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

VITAL STATISTICS to be completed by dental staff: _____

BP_____/_____ Pulse _____ Air Way Class _____

ASA = _____ Resp_____ Height _____

Weight_____

History of post-operative complications: _____

DENTAL HISTORY for _____ Exam Date_____

What toothpaste brand do you use? _____

Do you have sensitive teeth/gums? ___No ___Yes
If yes, please circle when sensitivity noted: Cold Hot Sweets Chewing Other_____

Do you floss or use interproximal brushes regularly? ___No ___Yes Location_____
Do you catch floss or food between your teeth? ___No ___Yes Location_____
Do you have spaces between your teeth? ___No ___Yes Location_____
Do you have missing teeth? ___No ___Yes Location_____
Do your gums bleed when you brush/floss? ___No ___Yes Location_____
Do your gums bleed when you chew? ___No ___Yes
Do your gums bleed when you get your teeth cleaned? ___No ___Yes
Do you ever wake up with blood on your pillow? ___No ___Yes
Do you have bad breath/taste? ___No ___Yes
Do you have frequent headaches? ___No ___Yes
Do you have frequent neck aches? ___No ___Yes
Do you wear a bite guard or night guard? ____No ____Yes

Circle any of the following that you have had done:

Fillings	Crowns	Bridges	Partial Dentures	Full Dentures
Implants	Root Canal	Braces	Gum Treatment	Extractions

Have you ever been referred to a periodontist before? ___No ___Yes
When?_____
Did you receive recommended treatment? ____No Why not? _____
_____Yes When & type of treatment _____

Did you have periodontal treatment with a general dentist before? ____No ____Yes, type of treatment _____

Would you be upset if you had to lose your teeth? ___No ___Yes

How often do you get your teeth cleaned by a dentist? Once every _____ months

As you understand it, your dentist referred you to this office to:

___treat gum disease	___to treat gum recession	___treat bone loss
___to place implants	___to treat infection	___to prevent gum problems after braces
___to continue periodontal maintenance	___other_____	

Office Notes:_____