Orlando Periodontics & Implants

WELCOME!

Today's Date: [Date]	General Dentist:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	Title:	Marital status:

Is this your legal name? ◯ Yes ◯ No	If not, what is your legal name?	Former name:	Birth date:	Age:	Sex: ◯ M ◯ F

Address:

Social Security no.:	Home phone no.:	Cell phone no.:
Occupation:	Employer:	Employer phone no.:

Referred by (Please choose one option): ◯ [Doctor's name] ◯ Other

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: [Birthday]	Address (if different):	Home phone no.:
Is this person a patient here?	◯ Yes ◯ No	Is this patient covered by insurance?	◯ Yes ◯ No
Occupation:	Employer:	Employer address:	Employer phone no.:

Please indicate primary insurance: Other:

Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber: Other:

Name of medical insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: Other:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Orlando Periodontics & Implants or insurance company to release any information required to process my claims.

____ _______________________________________

Patient/Guardian signature Date

DENTAL HISTORY

Purpose of today's visit:	Date of last visit:	What was done:

How often do you brush?	How often do you floss?	Do you use a water pik?	Do your gums bleed?

MEDICAL HISTORY

Are you currently under the care of a physician? ◯ Yes ◯ No

Physicians Name:	Telephone:	Address:
Has there been a recent change in your health? ◯ Yes ◯ No	Explain:	Height: ________ Weight: ________
Are you taking any medications (please list): ______________________ ______________________ ______________________ Are you or have you taken any bone density meds, or bisphosphonates within the past 12 years? ◯ Yes ◯ No	Have you been hospitalized or had serious illness in the past five years? ◯ Yes ◯ No	Are you pregnant or is likely that you could be pregnant at this time? ◯ Yes ◯ No

Circle if you have or ever had:

Y N Asthma
Y N Anemia
Y N Rheumatic fever
Y N High blood pressure
Y N Low blood pressure
Y N Mitral valve prolapse
Y N Heart murmur
Y N Chest pan/Angina
Y N Heart attack(s)
Y N Irregular heart beat
Y N Cardiac pacemaker
Y N Heart surgery
Y N Damaged heart valves
Y N Pneumonia/Bronchitis
Y N Chronic fatigue/Night sweat
Y N Trouble climbing 1-2 flights of stairs

Y N Abnormal bleeding
Y N A history of alcohol abuse
Y N A history of drug abuse
Y N Ado you use chewing tobacco
Y N Do you smoke?
If so, # packs a day _______
Y N Mental health problems
Y N Problems with immune system
Y N Delay in healing
Y N Hay fever/Sinus problems
Y N Snoring
Y N Sleep apnea/CPAP
Y N Respiratory problems
Y N Tuberculosis
Y N Emphysema
Y N Chronic cough

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

Y N Sexually transmitted diseases
Y N Contagious diseases
Y N Infectious mononucleosis
Y N Swollen ankles
Y N Arthritis/Joint disease
Y N Prosthetic implant
Y N Joint replacement
Y N Osteoporosis/Osteopenia
Y N Osteonecrosis
Y N Stomach ulcers
Y N Tumor or growth
Y N Cancer/Radiation/Chemotherapy
Y N Are you on a diet
Y N Contact lenses

Are you allergic to, or had a reaction to:

Y N Penicillin
Y N Sodium pentothal/Valium/other tranq.
Y N Soy
Y N Sulfa drugs
Y N Amoxicillin
Y N Latex

Y N Aspirin
Y N Eggs/Yolk
Y N Local anesthetic (numbing med)
Y N Codeine or other narcotics
Y N Sulfites
Y N Do you have any known allergies:
____

Below for women only:

Are you nursing? ◯ Yes ◯ No
Expected delivery date: _______________
Are you taking birth control pills? ◯ Yes ◯ No

NOTICE OF PRIVACY PRACTICES

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.

______________________________________ ______________________________

Patient/Guardian signature Date