Patient Registration and Medical History

Please complete this entire form and sign where indicated on pages #2 and 3.

PATIENT INFORMATION

First Name _____ MI _____ Last Name _____

How do you prefer to be addressed by the doctor & staff? _____ Sex: ___Female ___Male

Birth Date ___/___/____ Age _____ SS #_____-____-_____ Drivers License # & state _____

Address _____ City _____ State _____ Zip _____

Address 2 _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Ext. _____ Cellular _____

Email Address _____

Please indicate the preferred method to correspond with you: ___Home ___Work ___Cell ___Text ___Email

Marital Status: ___Married ___Single ___Divorced ___Separated ___Widowed

Employment Status: ___Full Time ___Part Time ___Retired ___Occupation: _____

Employer: _____

Spouse, Nearest Relative, or Emergency Contact: _____ Relationship to Patient: _____

Home Phone _____ Work Phone _____ Ext. _____ Cellular _____

Name of any relatives or friends treated at Forsyth Periodontal Associates: _____

DENTAL HISTORY

Referred By: _____ General Dentist: _____

Other Dental Specialists Seen: _____

Chief Dental Concern: _____

Are you having any discomfort at this time: ___No ___Yes If yes, please explain: _____

Have you had any trouble associated with past dental treatment: ___No ___Yes

If yes, please explain: _____

HEALTH HISTORY

For the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health.

Primary Physician _____ Date of last physical evaluation or medical visit: _____

City Location of Primary Physician _____ Phone # _____

Preferred Pharmacy: _____ Phone # _____

Height _____ Weight _____

Has your health changed in the past year? No Yes (please explain): _____

Have you been hospitalized, had a major operation, or a serious illness in the past 5 years?
No Yes (please explain): _____

Do you have any artificial joints or heart conditions that require antibiotics prior to dental treatment? No Yes

Do you currently smoke or have you smoked in the past? No Yes Packs/day: _____ If quit, since when? _____

Do you use any other nicotine products (gum, patch, lozenge, electronic cigarette)? No Yes

Are you taking now, or have taken in the last 2 years, any drugs for osteoporosis/osteopenia?
No Yes If yes, what drugs(s) & since when? _____

Have you had an adverse reaction or allergic reaction to any of the following:

Penicillins or other antibiotics	No	Yes	Narcotics (codeine, hydrocodone)	No	Yes
Local anesthetics	No	Yes	Sedatives or sleeping pills	No	Yes
Anti-inflammatories (Aspirin, Ibuprofen, etc)	No	Yes	Latex	No	Yes
Iodine	No	Yes	Other (please specify)	No	Yes

Have you ever been treated for alcohol or chemical dependency? No Yes (please explain): _____

Have you ever had any injury to the head, neck, or mouth? No Yes (please explain): _____

Have you ever experienced any problems with General Anesthesia or Conscious Sedation? No Yes

Women: Are you pregnant, think you are pregnant, or nursing? No Yes
Do you take birth control pills? No Yes
Have you reached menopause? No Yes

Have you ever been treated for any of the following:

Damaged heart valves	No	Yes	Asthma	No	Yes
Artificial heart valves	No	Yes	Emphysema, Bronchitis, COPD	No	Yes
Heart murmur	No	Yes	Infectious Disease (HIV, Hepatitis, MRSA, etc.)	No	Yes
Rheumatic heart disease	No	Yes	Epilepsy/seizures	No	Yes
Congenital heart problems	No	Yes	Autoimmune disease	No	Yes
Heart attack	No	Yes	Stomach ulcers or acid reflux	No	Yes
Heart surgery	No	Yes	Cancer, tumor, growth	No	Yes
Angina (chest pain)	No	Yes	Depression, anxiety, mental health problems	No	Yes
High blood pressure	No	Yes	Blood disorder (anemia, abnormal bleeding)	No	Yes
Heart stents	No	Yes	Sinus problems	No	Yes
Implanted pacemaker	No	Yes	Liver disease	No	Yes
Implanted defibrillator	No	Yes	Kidney problems	No	Yes
Stroke/TIA	No	Yes	Immune system problems	No	Yes
Diabetes	No	Yes	Vision problems or glaucoma	No	Yes

If diabetic: How often is bloodwork done? _____

What was your last A_1C? _____

Please list any prescription, non-prescription, or herbal medications you currently take or have taken regularly in the past 5 years:

Medication	Dosage/Frequency	Currently Taking (Y or N):

Have you ever been treated for any medical problem not listed above?
No Yes (please explain): _____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I also understand it is important to report any changes in my medical or dental status to the dentist at the earliest possible time, and I agree to do so. I will not hold my dentist or any other member of the staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____ _____ _____

Signature of Patient/Responsible Party **Date** **Signature of reviewing doctor** **Date**

Dental Management Considerations *(For completion by dentist or staff only)*:

DENTAL INSURANCE INFORMATION

Primary Dental Insurance

Subscriber Name: _____
Subscriber Employer: _____
Subscriber Birth Date _____
Subscriber SS# or ID: _____
Relation to Patient: _____
Insurance Company: _____
Group #: _____
Insurance Co. Phone: _____
Insurance Co. Address: _____
Insurance Co. City/State/Zip _____

Secondary Dental Insurance

Subscriber Name: _____
Subscriber Employer: _____
Subscriber Birth Date _____
Subscriber SS# or ID: _____
Relation to Patient: _____
Insurance Company: _____
Group #: _____
Insurance Co. Phone: _____
Insurance Co. Address: _____
Insurance Co. City/State/Zip _____

OFFICE GUIDELINES

Dental Insurance: We are committed to providing you with the best possible care and believe you should have a choice and control over your care. Therefore, we do not contract with dental insurance plans, nor do we accept the assignment of insurance benefits. As your health care provider, our relationship and concern is with you and your health, not the insurance company. Please note that:

- Dental insurance is a contract between your Employer and the Insurance Company to assist you in meeting dental financial obligations. Your employer chooses the plan and benefit level, not based upon the treatment needed.
- Dental insurance is an aid and is NOT designed to cover all treatment costs.
- Most plans are written to cover only minimal care. We are a specialty practice performing state of the art procedures providing long-term benefits for our patients. Unfortunately, some plans have not kept pace with medical and dental science, choosing only to cover older, less reliable treatments. Additionally, while over the last twenty years costs of dental treatment have risen in accordance with the cost of living, the amount and yearly limitations of dental insurance have virtually stayed the same.

We ask that treatment fees in our office be paid in full by the patient. As a courtesy, we will prepare the insurance claim for you to file for reimbursement. Occasionally, dental insurance companies send payments directly to our office. If this occurs, we will issue a refund check to you as soon as possible. Many times, dental insurance companies will request additional information such as dental records, x-rays or narratives which may delay payment. Our office responds to these requests immediately, in order to expedite your reimbursement. Please be aware that some, or perhaps all, of the services provided by our office may not be covered by your dental insurance company. Please also note that our office is under an opt-out agreement with Medicare.

Financial Arrangements: Regardless of insurance coverage, and to avoid misunderstanding, a written treatment plan estimate and financial arrangements will be made prior to treatment. We accept cash, check, Visa, MasterCard, and Discover for your convenience. In addition, we offer interest free payment plan options through our practice or through CareCredit.

Broken Appointment Policy for Examinations and Non-Surgical Appointments

Your appointment has been reserved specifically for you. If you are unable to keep this appointed time we ask for 2 business days notice so that we may use this appointment for another patient. Consistent broken appointments, late arrival (requiring rescheduling), and appointments cancelled with less than 2 business days notice may necessitate a broken appointment fee or our office being unable to reschedule you or continue with your treatment.

I acknowledge that I have read and understand the above Office Guidelines. I hereby authorize the release of all medical and dental information that is pertinent to my care to the insurance company or companies that may be required for them to process claims. Notwithstanding the fact that I may be entitled to dental insurance benefits, I understand that I am personally responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made.

_____ _____
Signature of Patient/Responsible Party **Date**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of this office's Notice of Privacy Practices.

_____ _____ _____
Signature of Patient/Responsible Party **Date** **Please Print Name**