PERIO HEALTH PARTNERS

Periodontal & Dental Implant Surgical Center

"Smile Healthy, Be Healthy"

www.PerioHealthPartners.com

Date: ____________________

Patient Information

Name: ____

❑ Ms. ❑ Mrs. ❑ Miss. ❑ Mr. ❑ Dr.

Marital Status: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Seperate ❑ Partnered

Birthdate: ____________________ Social Security #: ____________________

Home Address: ____

City: ____________________ State: __________ Zip: __________

Home Phone: ____________________ Cell: ____________________ Pager: ____________________

Email: ____________________ ❑ I would like to receive correspondences via email

Employer: ____________________ Work Phone: ____________________ Ext: ________

Referred by: ____

Person to contact in case of emergency: ____________________ Phone: ____________________

General Dentist: ____________________

Person financially responsible for this account (other than self): ____________________

Dental Insurance Information

Do you have dental insurance: ❑ Yes ❑ No

Name of Insured: ____________________ Relationship to Patient: ____________________

Insurance Company: ____________________ Group or Employer Number: ____________________

Policy #: ____________________ Policy Holders D.O.B.: ____________________

Insurance Co. Address: ____________________ City: ____________________ State: _____ Zip: __________

Insurance Co. Phone: ____________________ Employer: ____________________

Do you have secondary insurance? ❑ Yes ❑ No

Name of Insured: ____________________ Relationship to Patient: ____________________

Insurance Company: ____________________ Group or Employer Number: ____________________

Policy #: ____________________ Policy Holders D.O.B.: ____________________

Insurance Co. Address: ____________________ City: ____________________ State: _____ Zip: __________

Insurance Co. Phone: ____________________ Employer: ____________________

We will be happy to file your dental claims for you, regardless of your insurance company.

Mary Ann Lester, D.M.D

1815 South Clinton Avenue, Ste 500, Rochester, New York 14618 • *t* 585.376.5300 *f* 585.376.5302

Health History

Name____Date____________________________________

Date of last health care exam:_________ What was this exam for:___________________________________

Have you been hospitalized in the last 5 years? (please circle) No Yes

If yes, reason:____

Are you currently receiving medical care? No Yes If yes, nature of care: _________________________

Please list all the names and phone numbers of the dentists and physicians who are providing care for you:

1. General Dentist:____
2. Primary Care MD:____
3. Specialist MD:____
4. ____

For the following questions, please circle yes or no. Your answers are for our records only and will be confidential. Please note that our team may ask additional questions concerning your health in order to optimize your care.

Anemia or Blood Disorder	No	Yes	Hepatitis, any form	No	Yes
Diabetes—Type I or Type II Last HbA_1C- date_________value_______	No	Yes	Liver disease	No	Yes
Asthma Been hospitalized for condition?	No No	Yes Yes	Joint replacement- what joint__________ When placed?	No	Yes
COPD or other lung disease	No	Yes	HIV infection / AIDS or ARC	No	Yes
Abnormal bleeding	No	Yes	Kidney disease	No	Yes
Epilepsy, Seizure, fainting spells	No	Yes	Psychiatric Care	No	Yes
Abnormal Heart Beat	No	Yes	Stroke	No	Yes
Heart disease, Heart attack, and/or Heart surgery	No	Yes	Cancer or tumor Radiation or Chemotherapy	No	Yes
Heart stent when placed?	No	Yes	Glaucoma	No	Yes
Heart murmur, heart valve disease	No	Yes	Rheumatic fever	No	Yes
Heart and/or valve replacement	No	Yes	Recurrent sinus infections	No	Yes
Previous Bacterial Endocarditis	No	Yes	Slow healing mouth sores	No	Yes
Arthritis, Rheumatism, Inflammatory disease	No	Yes	Other conditions	No	Yes

Abnormal Blood Pressure? (please circle) No Yes What is your normal blood pressure?: _____________
Today (in office): BP____________ HR__________

Please list any dietary or herbal supplements you are taking and for what purpose:
1.____ 2.____
3.____ 4.____
5.____ 6.____

Reason for use:
Please list any medications (prescription and over-the-counter) you are currently taking, include any medication patches and meds for smoking cessation:
1.____ 2.____
3.____ 4.____
5.____ 6.____

Pre-medication prior to dental treatment?	No	Yes	Tagamet (cimetidine) or Prilosec (omeprazole)	No	Yes
Antacids?	No	Yes	Cardizem (diltiazem) or Calan, Isoptin (verapamil)	No	Yes
Dilantin or Tegretol?	No	Yes	Serzone (nefazodone)	No	Yes
Barbiturates	No	Yes	Diflucan (fluconazole) or Sporonox (itraconazole)	No	Yes
St. John's Wort or Kava-Kava	No	Yes	Biaxin (clarithromycin)	No	Yes
NSAIDS (ibuprofen) or Tylenol	No	Yes	Aspirin	No	Yes
Have you ever been treated with Bisphosphonate drugs (Fosomax, Aredia, Zometa, Actonel, Boniva?) If so when did treatment begin? When did treatment end?				No	Yes
Do you consume grapefruit juice, grapefruits or grapefruit extract?				No	Yes

Allergies/Adverse Reactions

Are you allergic or have you had a reaction to: Type of Reaction

a. Latex or Metals No Yes ______________________________

b. Antibiotics No Yes ______________________________

which? (please circle) Penicillin;.. Sulfa; Erythromycin; Tetracycline, other_______________ ______________________________

c. Aspirin, Ibuprofen, Tylenol No Yes ______________________________

d. Local anesthetics, including topical No Yes ______________________________

e. Codeine, Valium, or other sedatives No Yes ______________________________

f. Sulfites or preservatives No Yes ______________________________

g. Other________________________ ______________________________

Women:

a. Are you pregnant? No Yes

b. Are you a nursing mother? No Yes

c. Menopause? No Yes

Tobacco, Alcohol, Drugs

Do you use tobacco? If yes circle type: smoke chew How much per day? For how many years?	No	Yes
Do you want to quit using tobacco?	No	Yes
Have you used or smoked tobacco in the past? How much? How long since you've quit?	No	Yes
Do you consume alcohol? If yes, approximately how many drinks per week?	No	Yes
Do you use any mood altering drugs other than those listed previously	No	Yes

Is there anything else we should know about your health that was not covered by this questionnaire? ______________________________

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____

____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health and medication.

______________________ ______________________ ______________

Patient (Print Name) *Patient Signature* *Date*

______________________ ______________________ ______________

Doctor (Print Name) *Doctor Signature* *Date*

Office Financial Policy

It is our policy to discuss treatment plans with all patients or guardians before dental treatment is started. A complete estimate of fees and method of payment will be discussed after the initial consultation.

Dental Insurance:

This office is happy to cooperate with individuals who are covered by dental insurance. We only ask that you carefully read your policy to be sure that you are fully aware of any restrictions that apply to the benefits provided. Dental insurance is a contract between the patient and the insurance company. The doctors here at Periodontal Health Specialists are participants with Blue Cross/Blue Choice/Excellus Dental insurance programs.

To prevent any misunderstanding concerning dental insurance payment, the following policy has been established:

1.) Payment must be made as treatment progresses and surgery must be paid in full one week prior to your scheduled date.
2.) We will complete and mail your insurance forms for you. Please keep in mind, however, that you are responsible for payment for services rendered.
3.) A pre-estimate form can be submitted to your insurance company for authorization of benefits prior to treatment being started. Keep in mind that these take 4-6 weeks for a reply from most insurance companies.

PLEASE NOTE:
Predeterminations are not a guarantee of payment. It is the patient's responsiblility to know how much of their yearly benefit is remaining for the year. Most insurance companies have web sites for your convenience to access what benefits you have used and have left for the year.

Method of Payment:

1.) Full payment at each appointment is expected in the form of cash, check, credit card (Visa, MasterCard, Discover, Debit, American Express or Care Credit)
2.) If you would need to make payment arrangements, please see our front desk for information on financing through Care Credit.
3.) Interest charges of 1.5% per month are placed on the account if payment is sixty (60) days past due.

Cancellation Policy:

THERE WILL BE A $300.00 CHARGE FOR ANY SURGICAL APPOINTMENT CANCELED WITHOUT ONE (1) WEEKS NOTICE. THERE WILL BE A $50.00 CHARGE FOR ANY HYGIENE APPOINTMENT CANCELED WITHOUT 48 HOUR NOTICE.

I have read and understand my financial responsibility at Periodontal Health Specialists. If my account goes past due 90 days, I understand that I will be responsible for any charges associated with collection proceedings.

Patient Signature:____ Date:__________________________