LA PERIODONTICS & IMPLANT SPECIALISTS

Medical History

Indicate which of the following conditions/allergies you have or have had. By checking the box it will indicate a "YES" response, leaving blank will indicate a "NO" response.

- ☐ A-Fib
- ☐ Anxiety
- ☐ Asthma
- ☐ Blood Thinners
- ☐ Chemo/Radiation
- ☐ Cholesterol
- ☐ COVID Vaccine
- ☐ Cholesterol
- ☐ Dizziness
- ☐ GERD
- ☐ Head Injuries
- ☐ High Blood Pressure
- ☐ Heart Murmur
- ☐ Herpes (Oral)
- ☐ Joint Replacement
- ☐ Low Blood Pressure
- ☐ Pacemaker
- ☐ Respiratory Problems
- ☐ Stomach Problems
- ☐ Anesthesia
- ☐ Arthritis
- ☐ Bisphosphonates
- ☐ Cancer
- ☐ Circulatory Problems
- ☐ Depression
- ☐ Excessive Bleeding
- ☐ Graves' Disease
- ☐ Heart Arrhythmia
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Migraines
- ☐ Osteoporosis
- ☐ Pregnancy
- ☐ Psych Care
- ☐ Sinus Problems
- ☐ Thyroid Condition
- ☐ Tumors
- ☐ Tonsilitis
- ☐ Rheumatoid Arthritis
- ☐ Angina
- ☐ Artificial Joints
- ☐ Blood Disease
- ☐ Celiac Disease
- ☐ COPD
- ☐ Diabetes
- ☐ Fainting
- ☐ Hay Fever
- ☐ Heart Disease
- ☐ Herpes (Genital)
- ☐ Jaundice
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Pre-Medication
- ☐ STD
- ☐ Tobacco Use
- ☐ Ulcers
- ☐ Vertigo
- ☐ Other

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If you listed **Other**, please specify: _____

Please list any **Allergies** _____

Please circle any of the following that apply:

Recently hospitalized (illness or injury): Yes / No_____

Presently being treated for any other illness: Yes/ No _____

FEMALE: taking birth control pills FEMALE: Currently pregnant and/or breast feeding

Do you smoke or use tobacco? Yes No
Do you drink alcohol? Yes No
Do you take aspirin regularly? Yes No

Do you have any drug allergies or have you ever had an adverse reaction to any medication or anesthesia, or if any conditions or alerts selected need further clarification, please describe below:

_____
_____
_____
_____

Do you take antibiotic premedication for your dental visits? If yes, please explain.

_____
_____
_____
_____

Please circle your estimate of your general health:

Excellent Good Fair Poor

Name of your physician and phone number:

_____
Name Number

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

_____
_____
_____
_____
_____

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List all medications (prescription and non-prescription) including regular doses of aspirin:

_____

_____

_____

Preferred Pharmacy:

Name: _____ Address: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any changes in my health, I will inform the doctor at the next appointment without fail.

_____	_____	_____
Printed Name	Signature	Date

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ATTENTION:

Please check the following list of medications, if you are using any please circle. If you are NOT taking any of the below medications, please circle None and initial below with today's date.

Agent	Brand Name
Etidronate	Didronel
Clodronate	Bonefos, Loron
Tiludronate	Skelid
Pamidronate	APD, Aredia
Neridronate	Olpadronate
Alendronate	Fosamax
Ibandronate	Boniva
Risendronate	Actonel or Atelvia
Zoledronate	Zometa or Reclast
Estrogen	Multiple Brand
Calcitonin	Fortical or Miacalcin
Denosumab	Prolia™

NONE

If you circle any of the medications above, please list the date taken or if currently active:

_____

_____

_____

Signature: _____ Date: _____

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Patient Information

Patient Name: _____ Date: _____

Preferred Name: _____ Sex: M F SSN: _____

Title: Mr. Mrs. Ms. Mx. Dr. Family Status: Single Married Child Other

Birthdate: _____ Date of Prev. Visit: _____ E-mail: _____

Phone: _____ _____ _____ _____
Mobile Home Work Other

Address: _____

_____

Employment Information

The following is for: the patient the person responsible for payment both N/A

Employer Name: _____ Phone: _____

Employer Address: _____
Address City State Zip Code

Whom may we thank for referring you to our practice?

_____

In an emergency who should be notified?

_____
Name Relationship Phone Number

Primary Dental Insurance

Name of Insured: _____
Last First MI

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

Insured's Family Status: Married Single Child Other Insured's SSN#:_____

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Insurance Plan Name: _____

Insurance Company Phone Number: _____

Insured's Address:

_____

Address City State Zip Code

Insured's Phone Number: _____

Relationship to Insured: Self Spouse Child Other: _____

Secondary Dental Insurance

Name of Insured: _____

Last First MI

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

Insured's Family Status: Married Single Child Other Insured's SSN#:_____

Insurance Plan Name: _____

Insurance Company Phone Number: _____

Insured's Address: _

_____

Address City State Zip Code

Insured's Phone Number: _____

Relationship to Insured: Self Spouse Child Other: _____

Insurance Authorization: By signing I authorize my insurance company to pay the dentist all insurance benefits rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

_____ _____ _____

Printed Name **Signature** **Date**

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How would you rate the condition of your mouth (please circle one):

Excellent Good Fair Poor

Previous Dentist Name and Phone Number:

_____

Name Phone Number

Date of most recent dental exam and/or x-rays:

_____

_____

I routinely see my dentist every (please circle one):

3 months 4 months 6 months 12 months Not routinely

What is your immediate concern?

_____

_____

_____

_____

Check all that apply:

- ☐ Had complications
- ☐ Had trouble getting numb
- ☐ Had any reactions to local anesthetic
- ☐ Had/have braces, orthodontic treatment
- ☐ You experience dry mouth
- ☐ Any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth
- ☐ Food gets trapped between any teeth
- ☐ Have you ever whitened or bleached your teeth
- ☐ Have you ever experienced popping and/or clicking of your jaw joint
- ☐ You have difficulty chewing
- ☐ You clench or grind your teeth

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- ☐ You wear or have worn a bite appliance
- ☐ Gums bleed when brushing or flossing
- ☐ Treated for gum disease or were told you have lost bone around your teeth
- ☐ Noticed an unpleasant taste or odor in your mouth
- ☐ Experienced gum recession
- ☐ Had any teeth become loose on their own (without injury)
- ☐ Experienced a burning sensation in your mouth
- ☐ You snore or wake up frequently during the night

If any of the checked boxes needs further explanation, please describe:

_____

_____

_____

_____

Consent for Periodontal Services

I hereby authorize and request the above named doctor and her auxiliaries to perform for me all periodontal therapy and surgery indicated in my dental records and to do whatever procedures are deemed advisable in her judgment. I will discuss any aspect of my treatment I do not understand with my periodontist. I acknowledge that the benefits and risks of periodontal therapy are understood prior to accepting treatment. I also authorize and request the administration of such drugs and/or anesthetics as may be deemed advisable by the above named doctor. It has been explained to me, and I understand, that results are not, and cannot be, guaranteed or warranted. I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form. I have read the above conditions of treatment and payment and agree to their content.

_____	_____	_____
Printed Name	Signature	Date

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Consent for Services and Financial Policy

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed unless other arrangements are made. All accounts are due and payable at time of service rendered, unless prior arrangements have been made. If it is desired to extend payments for more than 30 days, specific arrangements must be made with our office. These extended payment courtesies are made at no interest or finance charge provided payments are received as promised. To avoid misunderstandings regarding dental insurance, we wish our patients to know that all professional services rendered are charged directly to the patient and that patients are personally responsible for payment of fees. We will prepare the necessary forms or reports to help you obtain your benefits from insurance companies. We do not render our services on the basis that insurance companies will pay our fees. I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination. A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied. I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination. I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

Printed Name	Signature	Date

Appointment Cancellation Policy

We understand that unforeseen events may arise, and you may need to cancel or reschedule your appointment. Our doctors & hygienists want to be available for your needs and the needs of all our patients. When a patient cancels last minute or does not show for a scheduled appointment, another patient loses an opportunity to be seen, there we have implemented our cancellation policy.

For Hygiene Visits: A $75 fee will be charged per scheduled hour if appointment is cancelled or rescheduled in less than 48 **business** hours.

For Surgical Visits: You will forgo the initial deposit of $300 if the appointment is cancelled or rescheduled in less than 72 **business** hours.

Thank you for being a valued patient and for your understanding and cooperation.

Printed Name	Signature	Date

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Informed Financial Consent

I, the undersigned patient, hereby authorize the undersigned provider to perform the procedure(s) or course(s) of treatment.

_____ _____
Patient Signature Date

_____ _____
Doctor Signature Date

Credit Card Information On-File

Name of Cardholder: _____

Please circle and provide us with one of the following:

VISA/MASTERCARD/AMEX: _____

Expiration Date: _____ Security Code: _____

Billing Address of Card:

_____

Street Address City State Zip Code

Print Name: _____

Signature: _____

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HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization. I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form. I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

Printed Name	Signature	Date

Consent for Internet Communications

I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice web site with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

Printed Name	Signature	Date

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