GSPerio

Patient Information

Name: ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. _____ ❑ Male ❑ Female
(Last / First / Middle)

Full Name of Husband, Wife, or Parent of Child _____

Address _____
(Street / City / State / Zip)

Home Phone _____ Work Phone _____ Cell Phone _____

Date of Birth _____ E-mail Address _____ Social Security # _____

Whom may we thank for referring you to our office? _____

Name of nearest relative or emergency contact not living with you? _____

Complete Address _____ Phone _____

Responsible Party Information

Name _____
(Last / First / Middle)

Residence Address _____

Home Phone _____ Work Phone _____ Cell Phone _____

Social Security _____ Date of Birth _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Dental Insurance Information

Insured's Name _____ Insured's ID # _____ Date of Birth _____

Insurance Company _____ Group # _____

Insurance Co. Address _____ Phone # _____

Insured Employer _____ Phone # _____

Do you have dual coverage? Yes ❑ No ❑ **If yes, Please complete the following secondary insurance information:**

Insured's Name _____ Insured's Soc. Sec # _____ Date of Birth _____

Insurance Company _____ Group # _____

Insurance Co. Address _____ Phone # _____

Insured Employer _____ Phone # _____

Dental Information

What is your chief complaint concerning your mouth today? _____

Do you currently have any teeth that are sensitive? Yes ❑ No ❑ If yes, please explain _____

When was the last time you saw a dentist? _____

When was your last professional cleaning? _____

How often do you brush your teeth? _____ How often do you floss your teeth? _____

Have you ever been treated for periodontal disease (gum disease)? ..... Yes ❑ No ❑

Do you feel that you can chew well with your teeth? ..... Yes ❑ No ❑

Do you grind or clench your teeth? ..... Yes ❑ No ❑

Do you ever have jaw pain or jaw muscle soreness? ..... Yes ❑ No ❑

Have you ever had an adverse reaction to local anesthetic? ..... Yes ❑ No ❑

Please complete back page

Medical Information

Please check "YES" or "NO" for each item

1. Are you having pain or discomfort at this time?..... Yes ❑ No ❑
2. Have you been a patient in the hospital during the past two years? ..... Yes ❑ No ❑
3. Have you been under the care of a medical doctor during the past two years? ..... Yes ❑ No ❑

   Physician's Name _____ Phone # _____

   Address _____ City _____
4. Are you taking any prescription medications, over-the-counter drugs, or recreational drugs?..... Yes ❑ No ❑

   If yes, please list all medications and the reason why you are taking them (or attach a separate list).

   _____

   _____
5. Are you allergic to any of the following?

Yes	No		Yes	No		Yes	No	
❑	❑	Penicillin	❑	❑	Latex	❑	❑	Other allergies (If yes, please explain):_____
❑	❑	Sulfa drugs	❑	❑	Local anesthetics			_____

6. Please indicate which of the following you have had or presently have. Check "**YES**" or "**NO**" for each item:

	YES	NO		YES	NO		YES	NO
Heart Disease, Attack, or Problem.....	❑	❑	Kidney trouble …….....	❑	❑	Liver Disease or Jaundice …….....	❑	❑
Angina Pectoris…….....	❑	❑	Ulcers …….....	❑	❑	Venereal Disease …….....	❑	❑
Heart Murmur or Rheumatic Fever....	❑	❑	Diabetes ……..…….....	❑	❑	AIDS or HIV Positive……..……..	❑	❑
Mitral Valve Prolapse…….....	❑	❑	Thyroid Problems ……..…….....	❑	❑	Herpes ……..…….....	❑	❑
High Blood Pressure…….....	❑	❑	Glaucoma……..…….....	❑	❑	Cold Sores/Fever Blisters …….....	❑	❑
Stroke……	❑	❑	Cancer or Tumors……..…….....	❑	❑	Epilepsy or Seizures ……..…….....	❑	❑
Arteriosclerosis……	❑	❑	Emphysema or Chronic Cough …....	❑	❑	Fainting or Dizzy Spells ……..……..	❑	❑
Artificial Heart Valve…….....	❑	❑	Tuberculosis ……..…….....	❑	❑	Nervousness Disorders ……..……..	❑	❑
Artificial Joints (hip, knee, etc.)……..	❑	❑	Asthma or Allergies ……..…….....	❑	❑	Drug Addiction……..……	❑	❑
Prolonged Bleeding ……..…….....	❑	❑	Hay Fever or Hives ……..…….....	❑	❑	Taken Fen-Phen……..……	❑	❑
Hemophilia ……..…….....	❑	❑	Sinus Trouble……..…….....	❑	❑	Disabled ……..…….....	❑	❑
Anemia ……..…….....	❑	❑	Hepatitis A, B, or C ……..…….....	❑	❑	Do you smoke or use smokeless tobacco?	❑	❑
Sickle Cell Anemia ……..…….....	❑	❑						

7. Are you currently taking a blood thinning medication, such as Aspirin, Plavix, Coumadin, Prodaxa, Effient or Xarelto?……..... Yes ❑ No ❑
8. Have you ever taken bisphosphonates to prevent bone loss of bone mass, such as Fosamax, Boniva, Actonel or Reclast?..... Yes ❑ No ❑
9. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or exhaustion?.... Yes ❑ No ❑
10. Have you ever been diagnosed with or treated for Osteoporosis, Osteopenia or Osteoarthritis?..... Yes ❑ No ❑
11. Do you have or have you had any diseases, condition, or problem not listed? ..... Yes ❑ No ❑

If yes, please list: _____

FOR WOMEN ONLY:

Are you pregnant? Yes ❑ No ❑ what month?_____ Are you nursing? Yes ❑ No ❑ Are you taking birth control pills? Yes ❑ No ❑

Consent:

1. I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.
2. The undersigned hereby authorizes doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.
3. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of patient)_____. I understand that using anesthetic agents embodies of certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.
4. I understand that all responsibility for payment for dental services provided in this office for myself of my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates. I understand that a 1 ½% finance charge (18% APR) may be added to my account.
5. I understand that where appropriate, credit bureau reports may be obtained.
6. I acknowledge I have received a copy of this Office's Notice of Privacy Practices and Financial Policy.

Patient Signature: _____ Date _____

Signature of Parent or Responsible Party: _____ Relationship to Patient _____

Office Reviewed_____

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