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Periodontics & Dental Implants

BAYTOWN PERIODONTICS
AND DENTAL IMPLANTOLOGY

Phone: (281) 427-5118
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4450 Baytown Central Blvd.
Baytown, TX 77521

PATIENT INFORMATION (CONFIDENTIAL)

NAME _____ DATE _____

ADDRESS _____ CITY _____ STATE _____ZIP_____

E-MAIL _____SS#_____BIRTHDATE_____ CELL#_____

CIRCLE APPROPRIATE BOX: MINOR SINGLE MARRIED DIVORCED WIDOWED SEPARATED

PATIENT/PARENT'S EMPLOYER _____ WORK PHONE_____

SPOUSE OR PARENT'S NAME _____ WORK/CELL PHONE_____

WHOM MAY WE THANK FOR REFERRING YOU? _____

EMERGENCY CONTACT NAME: _____ **PHONE NUMBER:**_____

RESPONSIBLE PARTY

PERSON RESPONSIBLE FOR THIS ACCOUNT_____ RELATIONSHIP TO PATIENT_____

ADDRESS_____ PHONE NUMBER _____

EMPLOYER_____ BIRTHDATE_____ SS#_____

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? YES NO

INSURANCE INFORMATION

NAME OF INSURED_____ RELATIONSHIP TO PATIENT_____

BIRTHDATE_____ SS#/ID#_____

NAME OF EMPLOYER_____ WORK PHONE_____

EMPLOYER ADDRESS_____

INSURANCE COMPANY_____ TEL#_____ GRP#_____

POLICY/ID#_____ INSURANCE ADDRESS_____

DO YOU HAVE SECONDARY INSURANCE? YES NO **IF YES, COMPLETE THE FOLLOWING**:

NAME OF INSURED_____ RELATIONSHIP TO PATIENT_____

BIRTHDATE_____ SS#/ID#_____

NAME OF EMPLOYER_____ WORK PHONE_____

EMPLOYER ADDRESS_____

INSURANCE COMPANY_____ TEL#_____ GRP#_____

POLICY/ID#_____ INSURANCE ADDRESS_____

HEALTH QUESTIONNAIRE

Today's Date _____ **Patient's Name** _____ **Birthdate** _____

Name of person completing this form (if different from patient) and relation to patient:

_____ *Relationship:* _____

Please answer the following questions to the best of your ability, realizing that true and accurate answers are important to the delivery of quality care. **All information you provide will be kept confidential.**

**** PLEASE ANSWER BY CHECKING OR CIRCLING Yes (Y) OR No (N) FOR EACH QUESTION ****

1. Are you in good health? …….. Y N
2. Has there been any change in your general health in the past year? ……... Y N
3. Date of last check up by physician: _____
4. Are you currently under a physician's care? ……... Y N
   If so, what for? _____
   Treating Physician's Name: _____ Phone Number: _____
5. Have you had any serious illness, operations, or hospitalizations? ……. Y N
   If so, describe and give approximate dates:
   _____
6. Have you ever had intravenous sedation or general anesthesia? ……. Y N
   Were there any adverse effects? _____
7. Do you generally tolerate dental treatment well? …… Y N

DO YOU HAVE OR HAVE YOU EVER HAD: (please circle all that apply)

A. Heart disease that was detected at birth? …… Y N
B. Rheumatic fever or Rheumatic heart disease? …… Y N
C. Cardiovascular disease (chest pain, heart trouble, heart attack, coronary artery disease, high cholesterol, high blood pressure, stroke, palpitations, heart surgery, angioplasty, pacemaker, A-fib, congenital heart disease, prosthetic heart valve, infective endocarditis)?.. Y N
D. Lung disease (asthma, emphysema, chronic cough, bronchitis, pneumonia, TB, shortness of breath, severe cough)? ……..... Y N
E Neurologic Disorders (seizure, epilepsy, fainting, dizziness, nervous disorder)?……..... Y N
F. Blood Disease (bleeding disorder, clotting disorder, anemia, blood transfusion, bruise easily)?... Y N
G. Liver Disease (jaundice, hepatitis)? …….. Y N
H. Kidney Disease? (ESRD, chronic kidney disease, stones) .....…… Y N
I. Diabetes? ……Latest A1C Value _____ Y N
J. Thyroid Disease (hypothyroidism, hyperthyroidism, tumor)? …….....……... Y N
K. Arthritis? (which joints _____)……. Y N
L. Stomach ulcers or intestinal problems? (GERD) …….. Y N

M. Have you ever been diagnosed or treated for cancer? ...…….. Y N

N. Vision Problems/Disease - Glaucoma? …….....…….. Y N

O. Frequent or recurring mouth sores (cold sores, fever blisters)?……. Y N

P. Prosthetic joint replacement? (hip, knee) ……..... Y N

Q. Radiation (x-ray treatment for cancer) in head and neck region? ……... Y N

R. Noises in jaw joint, pain near ear when chewing, do you grind or clench teeth? …….. Y N

S. Sinus or nasal problems? History of sinus surgery? _____ .....……. Y N

T. Any disease, drug or transplant operation that has suppressed your immune system? (HIV, AIDS, etc.) Y N

U. Recurrent infections of any kind? …… Y N

ARE YOU TAKING OR USING ANY OF THE FOLLOWING: (<u>please circle all that apply</u>)

A. Antibiotics? …… Y N

B. Anticoagulants (blood thinners)? (Plavix, Warfarin, Xarelto, Eliquis, etc.) ..... Y N

C. Thyroid medications? ……. Y N

D. Antihistamines, decongestants? ……. Y N

E. High blood pressure or heart medication? ..……... Y N

F. Steroids? (History of prolonged steroid use?)…….. Y N

G. Have you been diagnosed with an autoimmune condition? (Lupus, Fibromyalgia, RA, Lichen Planus) Y N

H. Do you pre-medicate for dental appointments? ……. Y N

I. Can you take Ibuprofen? .....…….. Y N

J. Aspirin, Ibuprofen, NSAIDS or anti-inflammatory drugs, narcotics or other pain relievers? …….. Y N

K. Weight reduction pills or diet aids (over the counter or "natural" products)? …….. Y N

L. Vitamins, natural remedies (ginko biloba, ephedra, ginseng, etc.) or other supplements? …… Y N

M. Marijuana, cocaine or other "recreational" drugs? …… Y N

N. Mental health - have you been diagnosed/treated for depression, anxiety, insomnia, bipolar disorder? Y N

O. Bisphosphonates for osteoporosis? Which kind? _____ Y N

P. IV Bisphosphonates – Aredia or Zometa? ……. Y N

<u>PLEASE LIST ALL CURRENT MEDICATIONS HERE: (Required)</u>

ARE YOU <u>ALLERGIC</u> TO OR HAD A BAD REACTION FROM: (<u>please circle all that apply</u>)

A. Local anesthetic (Novocain-like drugs)? …… Y N

B. Penicillin, Amoxicillin, Cephalosporins? ……... Y N

C. Other antibiotics? (Erythromycin, Azithromycin (Z-pack), Levaquin, Clindamycin, Keflex) ..... Y N

If so, please list: _____

D. Barbiturates, sedatives? (Versed, Fentanyl, Benadryl) .....…….. Y N

E. Aspirin, Ibuprofen, NSAIDS, Tylenol, Ketorolac, other pain medications? …….. Y N

F. Codeine or other narcotics or opioids? (Tylenol 3, Tramadol)……..... Y N

Hydrocodone? (Vicodin, Norco) ..... Y N

G. Latex? ……. Y N

H. Other allergies or reactions? …….. Y N

Please list:

GENERAL HEALTH:

A. Do you have hay fever, frequent skin rashes, etc.? …… Y N

B. Do you use alcohol? …… How much per day? _____ Y N

C. Do you smoke? …… Y N

Cigarettes- how many packs per day? _____ For how long? _____

D. Do you spit tobacco? ……...For how long? _____ Y N

E. Are you, or have you been, in a drug or alcohol recovery program? ……. Y N

F. Do you have any other disease, condition or problem not listed above that you think the doctor should know about (please describe in the comments below) ? …….. Y N

G. Do you wish to talk to the doctor privately about anything? ……...……..… Y N

H. Any additional comments? ……. Y N

<u>WOMEN</u>

A. Are you taking birth control pills? ……... Y N

B. Are you pregnant, trying to become pregnant or any chance you might be pregnant? …… Y N

C. Are you BREAST FEEDING? ……. Y N

D. Are you taking hormone replacement? …… Y N

I UNDERSTAND THE IMPORTANCE OF A TRUTHFUL HEALTH HISTORY AND REALIZE THAT INCOMPLETE INFORMATION MAY HAVE AN ADVERSE EFFECT ON MY TREATMENT. TO THE BEST OF MY KNOWLEDGE, THE INFORMATION ABOVE IS COMPLETE AND ACCURATE.

_____ _____

Date Signature of person completing Patent Information & Health History

OUR POLICY OF CARE AND PAYMENT

Ensuring that our patients receive high quality care is the goal of our practice:

We are committed to providing you with the best possible care. If you have dental insurance, we are anxious to help you receive the maximum allowable benefits. In order to achieve these goals, we need your assistance in understanding of our payment policy.

Payment is due at the time of treatment. We accept cash, check, and major credit cards. We also have a payment plan called CareCredit, that allows you to start treatment today and spread payments over time.

Applying for CareCredit only takes a few minutes and there is no fee to apply.

We will file with your insurance company. A deposit may be required on all scheduled surgeries unless other arrangements have been made and approved by our financial administrator.

We will gladly discuss your proposed treatment and answer any questions regarding relating to your insurance. You must realize, however, that:

1) Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.

2) Our fees generally fall within the acceptable range by most companies and therefore covered up to the maximum allowable determined by each carrier. This applies to companies who pay a percentage (such as 50°/o or 80°/o) of UCR, which is defined as usual and customary rates.

3) Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services that are not covered.

We must emphasize that as dental care providers, our relationship is with you, not your insurance company. While the filing of the claims is a courtesy that we extend to all of our patients, all charges are your responsibility from the date the service is rendered.

If you have any questions about the above information or any uncertainty regarding insurance coverage, PLEASE do not hesitate to ask. We are here to help YOU.

_____ _____

Signature Date

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry our treatment, payment, or healthcare options. I also understand you are not required to agree to my restrictions, but if you do agree than you are bound to abide by such restrictions.

Signature: _____ Date:_____