107 Frazier Ct. Suite 1D, Georgetown KY (502)-570-5700

THE FOLLOWING INFORMATION IS CONFIDENTIAL

Patients Name ______________________________________ Sex________ Weight_______

Date of Birth ________________________ Age________Social Security # __________________________

Residence Address ____
Street City State Zip

Telephone home# ____________________________cell #_______________________________

Email____

Employed by _____________________________Position _______________________

Name of Dentist ______________________________________

Who may we thank for referring you to this office? _______________________________________

Why were you referred to a periodontist?____

Name and address of insurance carrier ____

Policy number _______________________Person responsible for this account_________________

DOB_____________________ SSN#__________________________

Emergency contact Name & Phone Number____

Pharmacy____

GENERAL HEALTH

Yes No Are you now under the regular care of a physician?
If so, for what? ____

Yes No Are you taking any pills, medication or drugs?
If so, please list. ____

____

Yes No Have you had any unusual reaction or allergies to any medicines or foods?
If so, please list. ____

____

OVER->

GENERAL HEALTH (Continued)

Yes No Do you smoke?
Yes No Do you drink alcohol?
Yes No Have you had abnormal bleeding after a cut or a tooth extraction?
Yes No Are you pregnant?

………………. Do you have or have you ever had: (PLEASE CHECK)

____ HIV/AIDS
____ Rheumatic fever
____ Heart murmur
____ Heart attack
____ Arteriosclerosis
____ Diabetes
____ Stroke
____ Abnormal thirst
____ Osteoporosis
____ X-ray or radiation therapy
____ Problems in healing
____ Frequent headaches
____ Allergies
____Glaucoma
____ Frequent fractures
____ Condition requiring cortisone or other steroids
____ Hepatitis, jaundice or other liver disease
____ Shortness of breath or chest pains upon exertion
____ Tuberculosis, emphysema or other lung disease
____ Epilepsy, seizures, convulsions or fainting spells
____ Taken medicines for osteoporosis
____ Cancer/ cancer treatment
____ Alcoholism
____ Ulcers (stomach or duodenal)
____ Kidney or bladder trouble
____ High or low blood pressure
____ Thyroid or parathyroid disease
____ Asthma or difficulty breathing
____ Anemia or other blood disorder
____ Frequent vomiting or diarrhea
____ Arthritis or rheumatism
____ Painful or swollen joints
____ Rashes or skin disorders
____ Dizziness or light headaches
____ Sinus problems
____ Sexually related disease

CONSENT FOR TREATMENT

I authorize the dentist to perform diagnostic procedures and treatment necessary for proper dental care.
I authorize release of information concerning my (or my child's) healthcare, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits
I authorize the release of information concerning my (or my child's) healthcare, advice and treatment to another dentist.
I hereby authorize payments of insurance benefits directly to the dentist or dental group, otherwise payable to me.
I understand that my dental care insurance carrier or payer of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in part my dental care payer.

I attest to the accuracy of the information on this form.

PATIENT'S OR GUARDIAN'S SIGNATURE____________________________________

DATE____________________________________