



# CHRISTMAN PERIODONTICS

& DENTAL IMPLANT CENTER

Today's Date \_\_\_\_\_

### PATIENT INFORMATION:

Mr.  Mrs.  Ms.  Dr. First Name \_\_\_\_\_ M.I. \_\_\_\_\_ Last Name \_\_\_\_\_

Sex:  Male  Female Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_ E-mail \_\_\_\_\_

Street \_\_\_\_\_ Apt. \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Tel.( \_\_\_\_\_ ) \_\_\_\_\_ Cell.( \_\_\_\_\_ ) \_\_\_\_\_ Have you ever been a patient of our practice?  Yes  No

**Referred By** \_\_\_\_\_ Has a family member ever been a patient of our practice?  Yes  No

Dentist \_\_\_\_\_ Orthodontist \_\_\_\_\_

Medical Doctor \_\_\_\_\_ Driver's Lic.# \_\_\_\_\_

Employer \_\_\_\_\_ Bus. Tel.( \_\_\_\_\_ ) \_\_\_\_\_ Ext. \_\_\_\_\_

In case of emergency, please contact \_\_\_\_\_ Tel. ( \_\_\_\_\_ ) \_\_\_\_\_ Relation \_\_\_\_\_

### INSURANCE INFORMATION:

**Student:** . . . . .  Full Time  Part Time  Not . . . . . School Name and Address \_\_\_\_\_

**Marital Status:** .  Married  Divorced  Widow  Single  Legally Separated \_\_\_\_\_

**Employed:** . . . .  Full Time  Part Time  Retired  Not . . . . . Do you belong to a PPO or HMO?  Yes  No

### WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT:

Self (If self, skip this section)  Spouse  Father  Mother  Other \_\_\_\_\_

Name \_\_\_\_\_ S.S.# \_\_\_\_\_ Birth Date \_\_\_\_\_ Age \_\_\_\_\_

Tel.( \_\_\_\_\_ ) \_\_\_\_\_ Cell. ( \_\_\_\_\_ ) \_\_\_\_\_ E-mail \_\_\_\_\_

Street \_\_\_\_\_ Apt. \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Driver's Lic.# \_\_\_\_\_ Employer \_\_\_\_\_ Bus. Tel.( \_\_\_\_\_ ) \_\_\_\_\_ Ext. \_\_\_\_\_

### SPOUSE OR OTHER GUARANTOR INFORMATION: (IF DIFFERENT FROM ABOVE)

Name \_\_\_\_\_ Relation \_\_\_\_\_ S.S.# \_\_\_\_\_ Birth Date \_\_\_\_\_

Street \_\_\_\_\_ Apt. \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Tel. ( \_\_\_\_\_ ) \_\_\_\_\_ Employer \_\_\_\_\_ Bus. Tel.( \_\_\_\_\_ ) \_\_\_\_\_ Ext. \_\_\_\_\_

### PRIMARY DENTAL INSURANCE COMPANY:

Employer \_\_\_\_\_

Bus. Address \_\_\_\_\_

Bus. Tel.( \_\_\_\_\_ ) \_\_\_\_\_ Plan \_\_\_\_\_

Ins. Co. Name \_\_\_\_\_ I.D. # \_\_\_\_\_

Address \_\_\_\_\_

Tel.( \_\_\_\_\_ ) \_\_\_\_\_ Group Name \_\_\_\_\_

Group # \_\_\_\_\_ Insured Party \_\_\_\_\_

Relation \_\_\_\_\_ Birth Date \_\_\_\_\_ Sex:  M  F

S.S. # \_\_\_\_\_ Tel.( \_\_\_\_\_ ) \_\_\_\_\_

Address \_\_\_\_\_

### PRIMARY MEDICAL INSURANCE COMPANY:

Employer \_\_\_\_\_

Bus. Address \_\_\_\_\_

Bus. Tel.( \_\_\_\_\_ ) \_\_\_\_\_ Plan \_\_\_\_\_

Ins. Co. Name \_\_\_\_\_ I.D. # \_\_\_\_\_

Address \_\_\_\_\_

Tel.( \_\_\_\_\_ ) \_\_\_\_\_ Group Name \_\_\_\_\_

Group # \_\_\_\_\_ Insured Party \_\_\_\_\_

Relation \_\_\_\_\_ Birth Date \_\_\_\_\_ Sex:  M  F

S.S. # \_\_\_\_\_ Tel.( \_\_\_\_\_ ) \_\_\_\_\_

Address \_\_\_\_\_

### SECONDARY DENTAL INSURANCE COMPANY:

Employer \_\_\_\_\_

Bus. Address \_\_\_\_\_

Bus. Tel.( \_\_\_\_\_ ) \_\_\_\_\_ Plan \_\_\_\_\_

Ins. Co. Name \_\_\_\_\_ I.D. # \_\_\_\_\_

Address \_\_\_\_\_

Tel.( \_\_\_\_\_ ) \_\_\_\_\_ Group Name \_\_\_\_\_

Group # \_\_\_\_\_ Insured Party \_\_\_\_\_

Relation \_\_\_\_\_ Birth Date \_\_\_\_\_ Sex:  M  F

S.S. # \_\_\_\_\_ Tel.( \_\_\_\_\_ ) \_\_\_\_\_

Address \_\_\_\_\_

### SECONDARY MEDICAL INSURANCE COMPANY:

Employer \_\_\_\_\_

Bus. Address \_\_\_\_\_

Bus. Tel.( \_\_\_\_\_ ) \_\_\_\_\_ Plan \_\_\_\_\_

Ins. Co. Name \_\_\_\_\_ I.D. # \_\_\_\_\_

Address \_\_\_\_\_

Tel.( \_\_\_\_\_ ) \_\_\_\_\_ Group Name \_\_\_\_\_

Group # \_\_\_\_\_ Insured Party \_\_\_\_\_

Relation \_\_\_\_\_ Birth Date \_\_\_\_\_ Sex:  M  F

S.S. # \_\_\_\_\_ Tel.( \_\_\_\_\_ ) \_\_\_\_\_

Address \_\_\_\_\_

## HEALTH HISTORY:

**To our patients:** Although oral surgeons primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the care that you will be receiving. Thank you for answering the following questions. Your answers are for our records only and will be considered confidential.

Reason for today's office visit? \_\_\_\_\_

- |                                                                                                                                   | Yes                      | No                       |
|-----------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| 1. <b>Height</b> _____ <b>Weight</b> _____ Are you in good health? .....                                                          | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have there been any changes in your general health in the past year? .....                                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you under the care of a physician? ..... <b>Date of last visit</b> _____                                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>If so, for what are you being treated?</b> _____                                                                               |                          |                          |
| 4. Have you had any illness, operation or been hospitalized in the past five years? .....                                         | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>If so, describe</b> _____                                                                                                      |                          |                          |
| 5. Do you have unhealed / recurrent injuries or inflamed areas, growths or sore spots in or around your mouth? .....              | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>If so, describe where</b> _____                                                                                                |                          |                          |
| 6. Do you have a prosthetic joint / implant? ..... <b>If so, describe where and when</b> _____                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you had a heart valve replacement or vascular graft? .....                                                                | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you ever had general anesthesia? .....                                                                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you, or a family member, had any unusual or serious reactions to general anesthesia? .....                                | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Has a physician or previous dentist recommended that you take antibiotics / premedicate prior to your dental treatment? ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Date of last eye exam _____                                                                                                   |                          |                          |

HAVE YOU HAD, OR DO YOU CURRENTLY HAVE:	YES	NO	NOTES
12. Rheumatic fever?			
13. Damaged heart valves / mitral valve prolapse?			
14. Heart murmur?			
15. High blood pressure?			
16. Low blood pressure?			
17. Chest pain / angina?			
18. Heart attack(s)?			
19. Irregular heart beat?			
20. Cardiac pacemaker?			
21. Heart surgery?			
22. Pneumonia, bronchitis, chronic cough?			
23. Asthma?			
24. Hay fever / sinus problems?			
25. Snoring?			
26. Sleep apnea / CPAP?			
27. Difficult breathing / other lung trouble?			
28. Tuberculosis?			
29. Emphysema?			
30. Do you smoke? If so, number of packs a day _____			
31. Do you use chewing tobacco?			
32. Blood transfusion?			
33. Blood disorder such as anemia?			
34. Bruise easily?			
35. Bleeding tendency / abnormal bleed?			
36. Hepatitis, jaundice, or liver disease?			
37. Infectious mononucleosis?			
38. Gallbladder trouble?			

HAVE YOU HAD, OR DO YOU CURRENTLY HAVE:	YES	NO	NOTES
39. Fainting spells?			
40. Convulsions / epilepsy?			
41. Stroke?			
42. Thyroid trouble?			
43. Diabetes? If so, <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2			
44. Low blood sugar?			
45. Kidney trouble?			
46. High cholesterol?			
47. Are you on dialysis?			
48. Swollen ankles / arthritis / joint disease?			
49. Osteoporosis / osteopenia?			
50. Osteonecrosis?			
51. Stomach ulcers / acid reflux?			
52. Contagious diseases?			
53. Sexually transmitted diseases?			
54. Problems with immune system? Possibly from medication / surgery, etc.			
55. Delay in healing?			
56. A tumor or growth?			
57. Cancer / radiation therapy / chemotherapy?			
58. Chronic fatigue / night sweats?			
59. Are you on a diet?			
60. A history of alcohol abuse?			
61. A history of drug abuse?			
62. Contact lenses?			
63. Eye disease / glaucoma?			
64. Mental health problems / anxiety / depression?			
65. A removable dental appliance?			
66. Pain or clicking of jaws when eating?			
67. Malignant hyperthermia?			



**PATIENT DISCLOSURE INSTRUCTIONS**

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

- Home Telephone
  - Okay to leave a message with detailed information
  - Leave message with call-back number only
- Work Telephone
  - Okay to leave message with detailed information
  - Leave message with call-back number only
- Mobile Telephone
  - Okay to leave message with detailed information
  - Leave message with call-back number only
- Written Communication
  - Okay to mail to my home address
  - Okay to mail to my work / office address
  - Okay to fax to number indicated
  - Okay to text to cell phone
- Other (Fax Etc.) \_\_\_\_\_

I allow you to give my clinical information to, or answer questions from (check all that apply):

- Spouse
- Parent
- Child
- Other (specify): \_\_\_\_\_
- None

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his / her staff, responsible for any errors or omissions that I have made in the completion of this form.

X \_\_\_\_\_ X \_\_\_\_\_ X \_\_\_\_\_ X \_\_\_\_\_  
 Signature of patient (Parent or Guardian if Minor)      Date      Reviewed by      Date

**FEES & PAYMENTS**

We make every effort to keep down the cost of your care. You can help by paying upon completion of each visit. Other arrangements can be made with our office manager depending upon special circumstances. An estimate of the charge for any procedure or surgery you may require will be given to you upon request. If you have any dental and/or medical insurance we will be glad to fill out the proper forms, but please complete the identifying information on this form.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company.** You will be responsible for all collection costs, attorneys fees, and court costs.

X \_\_\_\_\_ X \_\_\_\_\_  
 Signature of patient (Parent or Guardian if Minor)      Date

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

X \_\_\_\_\_ X \_\_\_\_\_  
 Signature of patient: (Parent or Guardian if Minor)      Date

**AUTHORIZATION**

I authorize my surgeon and his / her designated staff, to perform an oral and maxillofacial examination, for the purpose of diagnosis and treatment planning. Furthermore, I authorize the taking of all x-rays required as a necessary part of this examination. In addition, if medically necessary, I authorize the release of any information acquired in the course of my examination and treatment to my other doctors and/or insurance carriers.

X \_\_\_\_\_ X \_\_\_\_\_ X \_\_\_\_\_  
 Signature of patient (Parent or Guardian if Minor)      Doctor's Signature      Date

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

X \_\_\_\_\_ X \_\_\_\_\_  
 Signature of patient (Parent or Guardian if Minor)      Date