Greater St. Louis Periodontics & Implants **Patient Information**

Date:_____

PATIENT INFORMATION:

Name		Marital Status
Home Address		Spouse Name
City, State and Zip		Emergency Contact Name
Phone (H) (M) (W)		Emergency Contact Relationship
Birth Date		Emergency Contact Phone (W) (H) (M)
Employer		
Business Address (City, State and Zip)		**General Dentist**
Business Phone		**Referred By:**

RESPONSIBLE PARTY INFORMATION:

Name		Relationship to Patient
Address		City, State and Zip
Emergency Contact Phone (H) (M) (W)		

INSURANCE INFORMATION:

Primary Dental Insurance Company:_____

Address:_____ Phone # _____

Group # _____ ID # _____

Subscriber:_____ Employer:_____

Social Security Number: _____ Date of Birth: _____

Secondary Dental Insurance Company:_____

Address: _____ Phone # _____

Group # _____ ID # _____

Subscriber:_____ Employer:_____

Social Security Number: _____ Date of Birth:_____

MEDICAL INFORMATION

Physician's Name _____ Phone: _____

CIRCLE

1. Do you have pain in any area of your mouth? yes no
2. Are you in good health? yes no
3. My last Physical examination was on: _____
4. Are you under the care of a Physician? yes no
5. Have you been hospitalized with a serious illness within the last 5 years? yes no
   If yes, explain_____
6. Are you taking any medication drugs or pills? yes no
   If yes, list _____
7. Are you allergic or have you reacted adversely to any of the following medications?

[ ] Asprin	[ ] Nitrous Oxide	[ ] Valium	[ ] Penicillin
[ ] Tylenol	[ ] Darvon	[ ] Erythromycin	[ ] Scopolamine
[ ] Dolobid	[ ] Tetracycline	[ ] Local Anesthetic	[ ] Other Antibiotics
[ ] Codeine	[ ] Novocaine	[ ] Sleeping Pills	[ ] Nembual/Seconal
[ ] Demerol	[ ] Percodan	[ ] Synalogs DC	[ ] Xylocaine

8. Are you aware of being allergic to any other medication or substance? yes no
   If yes, list _____
9. Indicate if you have or have had any of the following conditions? :

[ ] Heart Trouble	[ ] Bleeding Problems	[ ] Hepatitis (liver disease)
[ ] Heart Attack	[ ] Kidney Disease	[ ] Blood Transfusions
[ ] Heart Murmur	[ ] Glaucoma	[ ] Diabetes
[ ] Tumor or Growth	[ ] Tuberculosis	[ ] Radiation Therapy
[ ] Anemia	[ ] Stroke	[ ] High Blood Pressure
[ ] Ulcers	[ ] Convulsions	[ ] Venereal Disease
[ ] Arthritis	[ ] Jaundice	[ ] Rheumatic Fever
[ ] Asthma	[ ] Epilepsy	[ ] Hypoglycemia (low sugar)

10. Do you have any disease, condition or problem not listed above?
    If yes, explain _____
11. Do you get up often at night to urinate? yes no
12. Are you thirsty much of the time? yes no
13. Has anyone in your family had diabetes? yes no
14. Do you smoke? yes no
    If yes, how much?_____
15. Have you ever been tested for an AIDS related condition? yes no

For Women only:
Are you pregnant? yes no
If yes, what month?_____
Are you taking birth control pills? yes no

DENTAL INFORMATION

1. When was your last dental examination? _____
2. Frequency of dental care: _____regular _____periodic _____emergency
3. Have you lost any teeth? yes no
   If yes, reason _____
4. Have you ever had periodontal (gum) therapy?
   If yes, when and by whom? _____
5. Do your gums bleed? yes no
6. Have you noticed any loose teeth? yes no
   If yes, how long? _____
7. Do you think your teeth are effecting your general health in any way? yes no
8. Are you satisfied with the appearance of your teeth? yes no
9. Do you have any sensitive teeth? yes no
10. Do any of your relatives have periodontal disease? yes no
11. Please list any other pertinent dental information.

_____

1. All fees are due and payable at the time of service, unless prior arrangements have been made. We accept cash, check, MasterCard, Visa and Discover. If insurance is available, the patient will be given an itemized statement, which has the necessary information regarding services and fees to attach to their claim form to submit to their insurance company. *Third party coverage is a contact between the patient and his or her employer, **not** the Doctor.

2. Payments of portions that are *estimated* not covered are due at the time of the appointment. After 30 days of the procedure date, interest of 1.8% will be added to the statement balance each month unless prior arrangements have been made.

3. If you do have dental insurance, please present you insurance card for us to copy and you will be responsible for your co-payment and/or deductible(s) at the time of your appointment. We will then file your claim, and if a balance is remaining, you will be notified by mail.

4. This office cannot be responsible for negotiating a settlement on a disputed claim with the insurance company or Workers Compensation. Patient will assume responsibility for any fees and costs, including but not limited to attorney's fees, incurred as a result of enforcing payment for services rendered.

5. All professional services are charged to the patient and payment is the patient's responsibility. We do not determine insurance coverage. Insurance coverage is based upon what your employer has set up with the insurance company. Anything your insurance does not cover is your responsibility.

6. Patient will be charged for appointments cancelled or broken without 24 hours notice.

7. For insurance purposes, I authorize release of any information relating to services rendered and authorize payment directly to the provider. Medicare does not cover periodontal procedures.

I have read and understand the above policies and I will abide by this office policy.

Signature: _____Date:_____

Social Security #_____-_____-_____