



Periodontal Care, P.A.
Healthy Gums, Healthy Heart

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Welcome to Our Office

Please complete the following information so that we may better serve you.

Date: _____ General Dentist: _____

PATIENT INFORMATION

Title: Mr. Mrs. Ms. Miss Dr. Legal Name: _____

Preferred Name: _____ Birthdate: _____ Marital Status: _____

Address: _____ City: _____ State: _____ Zip: _____

Primary Phone: _____ Mobile Home

E-Mail Address: _____ Social Security #: _____ - _____ - _____

Employer: _____ Occupation: _____

If Patient is a Minor, Give Responsible Party's Name: _____ Relationship to Pt: _____

Pharmacy and Intersection Location: _____ Pharmacy Phone: _____

DENTAL INSURANCE INFORMATION (not medical):

Primary DENTAL Insurance:	Secondary DENTAL Insurance: (if applicable)
Subscriber Name: _____	Subscriber Name: _____
Relationship to Subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	Relationship to Subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other
Subscriber ID/SSN: _____	Subscriber ID/SSN: _____
Subscriber Date of Birth: _____	Subscriber Date of Birth: _____
Subscriber's Employer: _____	Subscriber's Employer: _____
Insurance Company: _____	Insurance Company: _____
Group#: _____	Group#: _____

EMERGENCY NOTIFICATION INFORMATION

Primary Care Physician: _____ Phone: _____

In case of an emergency, who should be notified?

Name: _____ Phone: _____ Relationship to Patient: _____

Periodontal Care, P.A. Financial Policy

The primary goal of our office is to provide you with the quality dental care you need. We will strive to make this as affordable as possible.

Please understand that your dental insurance was not created to pay for all your dental care needs. Unlike health insurance, dental insurance was created to assist with the costs of some preventative treatment needs; x-rays, simple cleanings, simple fillings, etc.... By nature of being in a periodontal office, your dental needs cannot be considered "simple" or preventative. Therefore, you should be prepared for some level of personal financial responsibility for the dental care received. We will assist you with your benefit eligibility before treatment to help calculate patient responsibility. This payment is due at the time of service.

We accept payment in the form of Cash, Check, Credit Card, and Care Credit

MISSED APPOINTMENTS

General Appointments- Unless cancelled at least 1 business day (24 hours) in advance, our policy is to charge for missed hygiene and new patient examination appointments at the rate of \$50.00 per hour. Please help us service you better by keeping scheduled appointments. This charge will be added to your bill at check out.

Surgical Appointments- Unless cancelled at least 2 business days in advance, our policy is to charge for missed surgical appointments at the rate of \$250.00 per appointment at the discretion of Periodontal Care, P.A. This charge will be added to your bill at checkout and 50% of your balance owed must be paid prior to being rescheduled.

_____ Initial

INSURANCE

Periodontal Care, P.A. provides insurance company billing as a courtesy to our patients. The patient portion of dental service(s) is estimated and due at the time of service. This amount may be subject to adjustment when the dental service(s) claim(s) are adjudicated by the insurance company. In addition, certain insurance companies have annual limitation for the amount of dental services that can be reimbursed within each plan year. If you or your family exceed these annual limitations in any plan year, you will be responsible for the full amount of dental services that exceed the plan's limitations. The patient is responsible for monitoring the amount of his/her remaining benefits for any annual benefit period. The patient may not rely solely upon any information provided by Periodontal Care, P.A. staff regarding his/her remaining benefit in any such benefit period. If you or your family has more than one dental insurance program, we will assist you in obtaining the maximum benefits available. You as a patient are always responsible for any charges that are not covered by your insurance.

_____ Initial

Medical Insurance

Periodontal Care, P.A. does not file medical insurance on any services. We are happy to provide you with the dental codes used and a form that you can fill out to file the medical claim with the help of your medical carrier.

DELINQUENT PAYMENTS

It is our policy to charge finance fees at 1.5% for outstanding patient balances after the balance has been outstanding 30 days. In addition, all payments returned due to non-sufficient funds will be subject to a NSF fee of \$25.00.

_____ Initial

_____ Initial

RESERVATION POLICY

Due to the extensive amount of time our staff and doctors devote to preparing and reserving uninterrupted time for surgical appointments, treatment plans over \$3,000 will require a 20% down payment to reserve your treatment time.

_____ Initial

I have read and agree to the Financial Policy and the Cancellation Policy of Periodontal Care, P.A.

Signature of Patient or Responsible Party: _____ Date: _____

Health History

Patient Printed Name: _____

Periodontal Disease Risk Factors:

Oral Care Habits: Toothbrush: Regular or Electric Floss: Regular/Waterpik/None Type of Mouth rinse: _____

Frequency of Dental cleanings: every 3 4 6 months Date of Last cleaning: _____

Family History of Gum Disease? YES NO

Previous Periodontal Surgery? YES NO Age: _____ Orthodontic Treatment? YES No Age: _____

Systemic Health Concerns: Date of last medical checkup/physical: _____

Have you been in the hospital in the past 2 years? YES NO Explain: _____

Current or Former smoker? YES NO Packs/day? _____ For how long? _____ Quit Date: _____

Current or Family History of Diabetes? YES NO Self/Mother/Father Type I or Type 2 Current A1C: _____

Current or Previous treatment for Osteoporosis/Bone cancer? YES NO Oral/IV treatment with: Boniva Fosamax Zometa

If YES, which medication and why? _____

Currently or previous treatment with immunosuppressive therapy? YES NO Use of Biologics such as Enbrel? YES NO

If YES, which medications and why? _____

Currently or previous treatment for an autoimmune condition? YES NO Use of Biologics such as Enbrel? YES NO

If YES, which medications and why? _____

Health History:

Do you take a blood thinner? YES NO Type: _____ How Long? _____ INR: _____

Do you have any prosthetic devices (e.g. heart valve or stent, artificial joint, implant, pacemaker, etc.)? YES NO

Do you require a Pre-Medication of antibiotics before dental procedures as ordered by a physician? YES NO

If YES, which antibiotic do you currently take? _____

FEMALES: Are you pregnant or thinking about becoming pregnant? YES NO

Are you allergic or sensitive to any medicine, dental anesthetic or latex products? YES NO

If YES, to what? _____

Prescription Medications or over-the-counter medications: **(attach separate sheet if needed)**

Medication and Dosage:	Why Taking:
1.	
2.	
3.	
4.	

Medication and Dosage (Cont'd):	Why Taking:
5.	
6.	
7.	
8.	

Is there any additional information (disease, condition or problem not listed) we should know of? YES NO

If Yes, Explain

To the best of my knowledge, the information I have given is true and correct. I understand that this will be held in confidence and it is my responsibility to inform Periodontal Care, P.A. of any future changes in my medical status.

Signature of Patient, Parent or Guardian: _____ Date: _____

Relationship to Patient: SELF PARENT GUARDIAN OTHER: _____

HIPPA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.
- Photos will often be taken of your case to be submitted for insurance purposes and occasionally used for marketing and education purposes.

May we phone, email, or send a text to you to confirm appointments?	YES	NO
May we leave a message on your answering machine at home or on your cell phone?	YES	NO
May we discuss your medical condition with any member of your family?	YES	NO

If YES, please name the members allowed:

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature: _____ Date: _____