Health History Form

PREMIER PERIODONTICS
PERIODONTAL & IMPLANT DENTISTRY
2933 W. Layton Ave.
Greenfield, WI 53221
(414) 282-2642
www.premierperio.com

Please let us know how you would like us to contact you.
Check the box next to your preferred method of communication. *(Only check one)*

Home Phone: ( )	☐	Work Phone: ( )	☐
Email Address:	☐		
Cell Phone: ( )	☐	Text ( )	☐

Name: Last First Middle

Address: Mailing address City: State: Zip:

Occupation: SS# or Patient ID DOB: Sex: M F

Emergency Contact: Relationship: Home Phone: Include area codes ( ) Cell Phone ( )

If you are completing this form for another person, what is your relationship to that person?

Your Name: Relationship

Primary Ins: Employer/ Group:
Subscriber: SS# DOB

Secondary Ins: Employer/ Group:
Subscriber: SS# DOB

Pharmacy: **Location:** **Phone Number:**

Dental Information For the following questions, Please (√) your responses to the following questions.

	yes	no
Do your gums bleed when you brush or floss?	☐	☐
Are your teeth sensitive to cold, sweets, or pressure?	☐	☐
Does food or floss catch between your teeth?	☐	☐
Is your mouth dry?	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐
Has a family member had any periodontal (gum) treatments?	☐	☐
Have you ever had orthodontic (braces) treatments?	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐
Is your home water supply fluoridated?	☐	☐
Do you drink bottled or filtered water?	☐	☐
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY		
Are you currently experiencing dental pain or discomfort?	☐	☐

	yes	no
Do you have earaches or pain in the front of the ear?	☐	☐
Do you notice popping or discomfort in the jaw?	☐	☐
Do you clench or grind your teeth?	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐
Do you wear dentures or partials?	☐	☐
Do you participate in active recreational activities?	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐

Date of your last dental exam:
Referred Dentist:
What was done at that time?

Date of last dental x-rays:

What is the main reason for your dental visit today?

How do you feel about your smile?

Medical Information Please (√) your response to indicate if you have or have not had any of the following diseases or problems.

	yes	no
Are you now under care of a physician?	☐	☐

Physician Name: Phone # Include area code ( )

Address/City/State/Zip:

	yes	no
Are you in good health?	☐	☐
Has there been any change in your general health within the past year?	☐	☐

If yes, what condition is being treated?

Date of last physical exam?

	yes	no
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐

If yes, what was the illness or problem?

	yes	no
Are you taking or have you recently taken any prescription or over the counter medicine(s)?	☐	☐

Is so, please list all, including vitamins, natural or herbal preparations and/or diet supplements:

_____

_____

_____

_____

Health form continued...

Medical Information

	yes	no
Do you wear contact lenses?	☐	☐
Are you taking or have you taken any diet drugs such as Pondimin (fenfluramine) Redux (dexphenfluramine) or Phen-fen (fenfluramine-phentermine combination?	☐	☐
Are you taking or scheduled to begin taking either of the medication, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease?	☐	☐
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?	☐	☐
Date Treatment began: _____		

	yes	no
Do you use controlled substances (drugs)?	☐	☐
Do you use tobacco or alternatives (smoking, snuff, chew, e-cigs)? If so, how interested are you in stopping? (Circle one) VERY / SOMEWHAT / NOT INTERESTED	☐	☐
Do you drink alcoholic beverages? If yes, how much alcohol did you drink in the last 24 hours? _____ If yes, how much do you typically drink in a week? _____	☐	☐
WOMEN ONLY Are you:		
Pregnant?	☐	☐
Number of weeks: _____		
Taking birth control pills or hormonal replacement?	☐	☐
Nursing?	☐	☐

Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? ☐ ☐
Date: _____ if yes, have you had any complications?

Allergies: Are you allergic to or have you had a reaction to:
To all YES responses, specify type of reactions.

	yes	no		yes	no
Local anesthetics _____	☐	☐	Metals _____	☐	☐
Aspirin _____	☐	☐	Latex (rubber) _____	☐	☐
Penicillin or other antibiotics _____	☐	☐	Iodine _____	☐	☐
Barbiturates, sedatives or sleeping pills _____	☐	☐	Hayfever/seasonal _____	☐	☐
Sulfa drugs _____	☐	☐	Animals _____	☐	☐
Codeine or other narcotics _____	☐	☐	Food _____	☐	☐
			Other _____	☐	☐

Please (√) your response to indicate if you have or have not had any of the following diseases or problems.

	yes	no		yes	no		yes	no		yes	no
Heart murmur	☐	☐	Blood transfusion	☐	☐	Chronic pain	☐	☐	Sleep disorder	☐	☐
Mitral valve prolapse	☐	☐	if yes, date _____			Diabetes Type I or II	☐	☐	Mental health disorders	☐	☐
Artificial heart valve	☐	☐	AIDS/HIV infection	☐	☐	Eating disorder	☐	☐	Specifiy: _____		
Rheumatic fever	☐	☐	Arthritis	☐	☐	Malnutrition	☐	☐	Recurrent infections	☐	☐
Damaged heart valve	☐	☐	Anemia	☐	☐	Gastrointestinal disorder	☐	☐	Type of infections: _____		
Congenital heart defects	☐	☐	Rheumatoid arthritis	☐	☐	GI/ Acid reflux	☐	☐	Kidney disorders	☐	☐
Cardiovascular disease	☐	☐	Auto immune disease	☐	☐	Heartburn	☐	☐	Night sweats	☐	☐
Angina	☐	☐	Systemic lupus erythematosus	☐	☐	Ulcers	☐	☐	Osteoporosis	☐	☐
Congestive Heart failure	☐	☐	Asthma	☐	☐	Thyroid problems	☐	☐	Persistent swollen glands in neck	☐	☐
Coronary artery disease	☐	☐	Bronchitis	☐	☐	Stroke	☐	☐	Severe headaches/ migraines	☐	☐
Heart attack	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐	Sexually transmitted diseases	☐	☐
Low blood pressure	☐	☐	Sinus trouble	☐	☐	Hepatitis, jaundice or liver disease	☐	☐	Excessive urination	☐	☐
High blood pressure	☐	☐	Tuberculosis	☐	☐	Epilepsy	☐	☐	High Cholesterol	☐	☐
Pacemaker	☐	☐	Cancer	☐	☐	Fainting spells or seizures	☐	☐			
Rheumatic disease	☐	☐	Chemotherapy	☐	☐	Neurological disorders	☐	☐			
Abnormal bleeding	☐	☐	Radiation Treatment	☐	☐	if yes, Specifiy: _____					

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ☐ ☐
Name of physician or dentist making recommendation: _____
Do you have any disease, condition, or problem not listed above that you think I should know about? ☐ ☐
Please explain: _____

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: _____ Date: _____

FOR COMPLETION BY DENTIST

_____

_____

_____

_____

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FINANCIAL POLICY

Thank You for choosing Premier Periodontics. We are committed to providing you with the highest quality dental care using the best material and technology available in the market today. We are also committed to providing you with up-to-date information and educational tools so that you can fully participate in maintaining optimum oral health. An important part of the mission is making the cost of your dental care easy and manageable by offering several payment options.

Payment Options

You can choose from:

- Cash, Check, Visa, Mastercard, and Discover
- Payment Plans from Care Credit (Please see a treatment coordinator for more information)
  * Allow you to pay over time with NO INTEREST
  * Convenient, low monthly payment plans are also available
  * No annual fees or pre-payment penalties

Please Note:

All charges you incur are your responsibility regardless of insurance coverage. *We must emphasize that as your dental care provider, our relationship is with you, not your insurance company. Your insurance policy is a contract between you and the insurance company.*

As a courtesy, we will help you process your insurance claims. You may direct your insurance company to pay your benefit directly to our office by signing the authorization on the Assignment of Benefits Agreement. In order for our office to file your insurance claims, you must bring proof of insurance to each appointment. Payment for all services is due at the time services are rendered.

Returned check and/or balances older than 60 days may be subject to collection fees and finance charges at the rate of 1.5% per month (18% annually) and any attorney fees that may apply. All accounts that are turned over to a Collection Agency will also be subject to any additional fees.

If you have any questions, please do not hesitate to ask. We are here to help you get the best dentistry that you want and need.

_____

Patient, Parent, or Guardian Signature Date

_____

Patient Name (Please Print)

Please continue on back →

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APPOINTMENT AGREEMENT

Welcome to our practice. We are honored that you have selected us for your dental needs and wants.

We are committed to providing quality service to all our patients.

We believe that an important aspect of delivering exceptional dental care is our patients' commitment to our practice as well.

Therefore, we request that you honor your reserved appointment as scheduled. Should you have to change your appointment for any reason, we ask that you give us 48 business hours notice.

Because missed appointments increase the cost of healthcare for everyone, should you miss two appointments in which 48 hours notice is NOT given, you may be required to pay a deposit before we reserve your next appointment. The deposit fee would then be applied to any treatment rendered, or forfeited if the reserved appointment is missed or cancelled without giving the required 48 hours notice. We appreciate your understanding in this matter.

Sincerely,

The Premier Periodontics Team

I have read, understand, and will honor the practice's Appointment Agreement:

Patient Signature Date

Premier Periodontics

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.
MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

_____ _____

Please ***print*** name of Patient Please ***sign*** for Patient / Guardian of Patient

_____ _____

Legal Representative / Guardian Relationship of Legal Representative / Guardian

Your comments regarding Acknowledgements or Consents: _____

_____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:
☐ First Name Only ☐ Proper Surname ☐ Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Cell Phone Confirmation ☐ Text Message to my Cell Phone
☐ Home Phone Confirmation ☐ Email Confirmation
☐ Work Phone Confirmation ☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

☐ Cell Phone Confirmation ☐ Text Message to my Cell Phone
☐ Home Phone Confirmation ☐ Email Confirmation
☐ Work Phone Confirmation ☐ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

☐ Phone Message ☐ **Any of the Above**
☐ Text Message ☐ **None of the above** (opt out)
☐ Email

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment ____
I could not communicate with the patient ____
The patient refused to sign ____
The patient was unable to sign because ____
Other (please describe) ____

_____
Signature of Privacy Officer