POULOS SOMERS

Dedicated To Excellence In Periodontics & Implantology

***The following information will make it possible for us to be more successful and thorough in your treatment. Your answers are for our records only and will be considered confidential.**

Name of Patient:_____
First Middle Last (Preferred Nickname)

Today's Date:_____Name of Dentist (or person) who referred you:_____

Reason for Your Referral **(In your own words)**:_____

_____

*If patient is a minor- Name of Father (or) Name of Mother:_____

Home Address:_____
(Street) (Unit #)

City:_____State:_____Zip:_____

Home Phone:_____ Cell:_____ E-Mail:_____

DOB:_____/_____/_____ Current Age:_____ Gender: M F Height:____'____" Weight:_____lbs.

Marital Status:_____ Occupation:_____

Emergency Contact: Name_____Phone#_____

Please list the name(s) of anyone who is authorized to discuss your account details:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Dental Benefits:

Dental Benefits Company:_____

Contact #:_____Group #:_____Subscriber #:_____

Name of Primary Subscriber : _____
Last First Middle Initial

Subscriber Birth Date:_____/_____/_____ Subscriber Social Security #_____-_____-_____

Subscriber's Relationship to Patient:_____

Address (if different than patient):_____Phone:_____

City:_____State:_____Zip Code:_____

Subscriber Employer:_____Business Phone:_____

Do you have a secondary dental benefit plan? Yes No

Medical & Dental History

- Are you currently under the care of a physician (medical doctor)? Yes No Unknown
- Name and phone number of your primary care physician:_____/_____
  (name) (phone#)
- Name and phone number of cardiologist or additional care provider:_____/_____
  (name) (phone#)
- Approximate date of your most recent physical exam:_____

Please mark an "X" on the appropriate spot if **you** have or ever had the following:

_____ Frequent/severe headaches
_____ TMJ pain, joint clicking/popping
_____ Heart Attack
_____ Heart Surgery
_____ Abnormal Blood Pressure (High/Low)
_____ Heart Murmur/Congenital Defect
_____ Congestive Heart Disease/Failure
_____ Shortness of breath or pain w/ exertion
_____ Angina (Chest Pain)
_____ Pacemaker
_____ Cardiac Stent
_____ Atrial Fibrillation
_____ Anemia or other blood disorder
_____ Bleeding Problems / Disorder
_____ Anti-coagulated (on "blood thinners")
_____ Stroke
_____ Cancer, tumors, or growths
_____ Radiation or Chemo-therapy

_____ Diabetes (Type I / Type II)
_____ Recent extreme weight loss/gain
_____ Healing Problems
_____ Joint Replacement
_____ Kidney Disease
_____ Hepatitis or other Liver Disease
_____ Thyroid/ Parathyroid Disease
_____ TB, Emphysema or other Lung Disease
_____ Epilepsy or Seizures
_____ Arthritis or Rheumatism
_____ Blood Clots/ Embolism/ Thrombosis
_____ HIV or other Venereal Disease
_____ Stomach Ulcers
_____ Asthma, COPD, trouble breathing
_____ Glaucoma
_____ Condition requiring use of Steroid Medications
_____ Frequent Bone Fractures/Dislocations
_____ Osteoporosis and/ or Osteopenia

- Please describe any other medical issues (not listed above) which may affect your medical/dental treatment with us:
  _____
- Have you ever experienced a complication with previous medical/ dental surgery or anesthesia? YES (please explain) NO
  _____
- Have you ever had an allergic reaction to any medication or medical supply (Latex, Iodine, antibiotics, etc)?
  YES (please list) NO
  _____
- Have you ever been told by your doctor to avoid taking non steroidal anti-inflammatory drugs (NSAIDs)? These include both prescribed and over-the-counter medications such as Ibuprofen, Advil, Naproxen, Aleve, etc? YES (please list) NO
  _____
- Have you ever been told by your doctor to avoid taking or limit your use of Tylenol or Acetaminophen? YES NO
  _____

Medical & Dental History

- Have you ever had an allergic reaction to an antibiotic? (Penicillin, Amoxicillin, Augmentin, Clindamycin, Azithromycin, Metronidazole, Tetracyclin, Minocyclin, Doxycyclin, Levaquin, others) YES (please list) NO

_____

- Have you ever had an allergy or other problems with pain medications such as Vicodin, Percocet, Codeine, Tramadol, Demerol, Tylenol, Hydrocodone, Oxycodone, etc? YES (please list/explain) NO

_____

- Are you currently taking any anti-coagulant drugs (blood thinners)? These can be prescribed or over the counter medications such as Aspirin, Warfarin, Coumadin, Xarelto, Heparin, Pradaxa. YES (please list) NO

_____

- Are you currently taking an SSRI medication (anitdepressant)? Medications in this category include Celexa (Citalopram), Lexapro (Escitalopram), Luvox (Fluvoxamine), Paxil (Paroxatine), Prozac (Fluoxatine) and Zoloft (Sertraline) YES (please list) NO

_____

- Have you been told by your doctor or dentist that you must take antibiotics prior to dental work? YES (please explain) NO

_____

- Are you now, or have you ever taken Bisphosphonate (bone sparing) drugs for the treatment of osteopenia, osteoporosis, cancer, etc? These can be administered either orally or via injection and include Fosomax, Boniva, Actonel, Acedia, Zometa etc .
YES (please explain) NO

_____

- Do you currently smoke or regularly use any tobacco product? (Cigarettes, cigars, pipes, e-cigarettes, smokeless, etc)
YES (please explain) NO

_____

- Are you a former tobacco user who has successfully quit? (Cigarettes, cigars, pipes, e-cigarettes, smokeless, etc)
YES (please explain) NO

_____

- Do you currently smoke/use marijuana in any form (Rx or recreational)? YES (how often and in what form?) NO

_____

- Are you pregnant? Could you be pregnant? YES NO
- Are you currently breastfeeding? YES NO
- Are you currently taking oral birth control pills? YES NO

- Do you have a family history of periodontal disease? YES NO
- Have you had any periodontal or oral surgery in the past? YES NO
- Have you ever had orthodontic treatment (braces, Invisalign, etc)? YES NO
- Do you wear a night guard or other night time appliance, CPAP, etc? YES NO
- Are you currently experiencing dental or oral pain? YES NO
- Do you think you have a dental phobia (fear of dentistry)? YES NO
- Are you interested in discussing your options for Sedation Dentistry? YES NO

- When is the last time you had a dental cleaning and examination with your regular dentist? _____

- Have you ever had a "deep cleaning and scaling" with numbing (anesthetic)? YES (when?)_____ NO UNSURE

Medical & Dental History

*Please list **all medications** you are currently taking **(include dose and frequency)**. **Be sure to include all prescriptions, over-the-counter medications, and recreational medications as well as all vitamins and supplements: These will remain confidential- Honesty & accuracy is extremely important!**

Medication:	Use:	Dose:	Frequency:	Notes:

x_____ _____

Patient Signature **Today's Date**

x_____

Signature of Parent (if patient is a minor)

Office Use Only:

Initial Visit BP:_____/_____ HR:_____ Sp%O2:_____ **ASA:** _____

Medical & Dental History

Financial Policy

Thank you for choosing Drs Poulos & Somers for your periodontal needs. Our primary goal is to offer state of the art treatment and deliver the best and most comprehensive dental care available. As a condition of the treatment performed by the providers in this office, **financial arrangements must be made in advance for the full cost of the proposed treatment.**

Payment Agreement Terms and Payment Information:

- Full payment or partial payment with arrangements is due at the time services are rendered. For your convenience we accept cash, Visa, MasterCard, Discover, personal check, money order, or registered check.
- Outside financing is available through Lending Club and Care Credit
- Any account balance defaulting past 60 days will automatically be audited for collection procedures. If the account is forwarded outside of our office you will be responsible for the balance on the account along with any and all charges accrued through the collection process.

Dental Benefits Information:

- Dental benefits are determined by your employer and not our office. Your dental benefit plan is not a guarantee of payment; nor will it pay for all of your costs. Your benefit policy is a contract between you and your insurer; we have no control over your plan. In order to make the dental benefits process go as smoothly as possible, we require patients to provide us with accurate policy and billing information before the time of service. In addition to a copy of your dental benefits card or printout of your information, please provide the social security number, birth date, and employment information of the insured. If processing of a claim is delayed due to lack of complete information from you, the balance in full will be your responsibility regardless of your coverage.
- As a courtesy we will be glad to file your claim for you but we do require a partial payment at the time of service. You will be expected to pay in full for services rendered if the office is unable to verify your insurance information before treatment. **If payment for services already rendered has not been paid in full within 60 days, either by you or your insurance company, the remaining balance for treatment is considered due and collectible.**
- Our office does not bill to medical insurance, and we do not accept Medicare or Medicaid. However, if you choose to file claims to a medical carrier, we will provide you with any supporting documentation that you need.We reserve the right to charge and collect fees for broken appointments; appointments that are cancelled or broken without 2 business days advance notice. Appointments are reserved exclusively for you. As a health benefit to you, we may offer to move your appointment to an earlier time if openings arise.

A Returned Check Fee of $35 will be added to your account balance and is collectible.
Courtesies cannot be combined and are not to exceed 5%.

Continued care timing may be suspended due to outstanding account balances.

**** Would you like to receive your statements electronically? Yes No**

By my signature, I certify that I have read and understand this policy.

x_____ _____

Patient Signature **Today's Date**

x_____

Printed Name

Medical & Dental History

HEALTH/DENTAL HISTORY UPDATES:

Updated (Date)	No Changes (NC) or Explain any changes below	Patient's Signature