PERIO ONE
PERIODONTICS OF ACADIANA

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BOARD CERTIFIED BY THE AMERICAN BOARD OF PERIODONTOLOGY

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PATIENT DEMOGRAPHIC INFORMATION

First Name: _____Last Name:_____ M.I._____

Email Address_____

Address _____Apt. No. _____

City, State, Zip _____

Home Phone (____)_____Work Phone (___)_____Other.#_____

Birthdate _____ Social Security # _____-_____-_____

Referred by _____Your General Dentist _____
(If Different from Referral)

DENTAL INSURANCE INFORMATION

Name of Insured_____Relationship to Patient_____

Insured's Birthdate _____ Soc. Sec. # _____-_____-_____

Employer_____Group # _____Group Name _____

Insurance Co. & Address_____

___I am not covered by any Dental Insurance at this time

I hereby authorize Periodontics Associates, LLP to release any and all medical and dental information pertinent to my treatment to the above Named insurance carrier(s) for the purposes of pre-authorization of treatment plan and fees, claims processing, utilization review or financial audit. In addition, I hereby authorize insurance payment directly to Periodontics Associates, LLP of the medical and dental benefits otherwise payable to me, for the services rendered to me by either doctors or their staff. I have been informed that this office will report my diagnosis, treatment and fees to my carrier(s)in according with standards conforming to the current procedures established by the American Academy of Periodontology, and that it is the sole power and responsibility of my carriers to determine the actual dollar amounts of benefits for all services rendered. I understand that I am ultimately responsible for the total costs of my treatment provided by Periodontics Associates, LLP

WE ARE NOT PARTICIPATING PROVIDERS FOR MEDICARE.

Cancellation Policy: To reschedule your appointment, please speak to someone at least 24 hours prior to the scheduled appointment time. This will ensure avoiding cancellation fees.

Payment: Payment is due at time of service. We accept cash, check, debit cards, major credit cards (Visa, Mastercard, and Discover), and Care Credit.

I acknowledge that I have read and understand the above statements and policies, and that this authorization remains valid and effective from the date of signing until revoked in writing.

_____ _____
Signature of Patient or Patient's Legal Guardian Date of Signature

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- o Individual refused to sign
- o Communications barriers prohibited obtaining the acknowledgement
- o An emergency situation prevented us from obtaining acknowledgement
- o Other (Please Specify)

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HEALTH QUESTIONNAIRE

NAME:_____ AGE _____ HEIGHT_____ WEIGHT _____

NAME OF MEDICAL DOCTOR:_____ MONTH/YEAR OF YOUR LAST MEDICAL EXAMINATION_____

YES NO IS YOUR GENERAL HEALTH GOOD?

YES NO HAS THERE BEEN ANY CHANGE IN YOUR GENERAL HEALTH IN THE PAST YEAR?

YES NO HAVE YOU EVER TAKEN ANY OF THE FOLLOWING MEDICATIONS FOR THE TREATMENT OF OSTEOPOROSIS OR BONE CANCER:

ZOMETA(ZOLENDRONATE),AREDIA(PAMIDRONATE), BONIVA(IBANDRONATE),ACTONEL(RISEDRONATE) OR FOSAMAX (ALENDRONATE)

YES NO HAVE YOU HAD A SERIOUS ILLNESS, OPERATION OR HOSPITALIZATION DURING THE PAST FIVE YEARS?

IF YES, PLEASE DESCRIBE _____

YES NO ARE YOU TAKING ANY PRESCRIBED MEDICATIONS AND/OR INHALERS??

IF YES, WHICH ONES _____

YES NO OVER THE COUNTER MEDICATIONS OR NATURAL OR HERBAL SUPPLEMENTS?

IF YES, WHICH ONES _____

YES NO HAS YOUR M.D. TOLD YOU TO TAKE ANTIBIOTICS PRIOR TO HAVING ANY TYPE OF DENTAL PROCEDURE?

YES NO ARE YOU ALLERGIC TO ANY MEDICATIONS, FOODS, DRUGS, LATEX, IODINE?

IF YES, WHICH ONES _____

YES NO HAVE YOU EVER HAD ADVERSE REACTION TO ANY DRUGS, ANESTHETICS, SEDATIVES, NARCOTICS, ASPIRIN, IBUPROFEN (MOTRIN)?

YES NO HAVE YOU EVER HAD EXCESSIVE BLEEDING THAT REQUIRED SPECIAL TREATMENT?

YES NO HAVE YOU BEEN DIAGNOSED AS HAVING ANY IMMUNODEFICIENCY, SYSTEMIC LUPUS, ARC OR AIDS?

YES NO IS THERE A HISTORY OF DIABETES IN YOUR FAMILY?

YES NO ARE YOU ON A SPECIAL OR RESTRICTED DIET OF ANY KIND?

YES NO DO YOU USE ANY KIND OF TOBACCO? IF SO HOW MUCH: _____ PER DAY, WEEK, MONTH

YES NO DO YOU USE ANY KIND OF ALCOHOL? IF SO HOW MUCH: _____ PER DAY, WEEK, MONTH

YES NO DO YOU HAVE ANY HISTORY OF SUBSTANCE ABUSE OR DO YOU CURRENTLY USE RECREATIONAL DRUGS?

FOR WOMEN, CHECK ALL THAT ARE APPROPRIATE: ☐ I AM PREGNANT ☐ I AM NURSING ☐ I AM TAKING BIRTH CONTROL PILLS

CHECK ALL OF THE FOLLOWING THAT YOU MAY HAVE HAD IN THE PAST OR THAT CURRENTLY APPLY TO YOU:

☐ CHEST PAIN UPON EXERTION	☐ SHORTNESS OF BREATH	☐ HIGH BLOOD PRESSURE	☐ LOW BLOOD PRESSURE
☐ HEART VALVE PROSTHESIS	☐ MITRAL VALVE PRO-LAPSE	☐ CONGENITAL HEART LESION	☐ RHEUMATIC FEVER
☐ HEART MURMUR	☐ DAMAGED HEART VALVE	☐ HEART ARRHYTHMIA	☐ TACHYCARDIA
☐ HEART SURGERY	☐ RADIATION THERAPY	☐ CHEMOTHERAPY	☐ HISTORY OF CANCER
☐ SLEEP APNEA	☐ ASTHMA	☐ BRONCHITIS	☐ EMPHYSEMA
☐ SINUS TROUBLES	☐ PERSISTENT COUGH	☐ TUBERCULOSIS	☐ JOINT REPLACEMENT SURGERY
☐ ARTHRITIS	☐ CONNECTIVE TISSUE DISORDER	☐ NEUROLOGICAL DISORDERS	☐ STROKE
☐ HEADACHES	☐ MIGRAINES	☐ EPILEPSY	☐ SEIZURES
☐ MENTAL HEALTH PROBLEMS	☐ GLAUCOMA	☐ WEAR CONTACT LENSES	☐ SEVERELY IMPAIRED VISION
☐ RECURRENT INFECTIONS	☐ CHRONIC FATIGUE	☐ RECENT WEIGHT LOSS	☐ DIABETES MELLITUS

Please list any other disease or medical problem that you have or have had that is ***NOT*** listed above:

_____

_____