

# Welcome to Summit View Periodontics

In order for us to best serve you, please complete the following information:

## PATIENT INFORMATION

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Driver's Lic. # \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Soc. Security # \_\_\_\_-\_\_\_\_-\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

Mobile Phone (\_\_\_\_) \_\_\_\_-\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_-\_\_\_\_

Work Phone (\_\_\_\_) \_\_\_\_-\_\_\_\_ E-mail address \_\_\_\_\_

Check Most Appropriate:  Single  Married  Divorced  Widowed  Separated  Minor

Who may we thank for referring you? \_\_\_\_\_

Current General Dentist \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_-\_\_\_\_

Emergency Contact \_\_\_\_\_ Relation \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_-\_\_\_\_

Preferred Pharmacy \_\_\_\_\_ Location \_\_\_\_\_

## RESPONSIBLE PARTY

Responsible Account Holder \_\_\_\_\_ Relation to Patient \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security Number \_\_\_\_-\_\_\_\_-\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

Mobile Phone (\_\_\_\_) \_\_\_\_-\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_-\_\_\_\_

Occupation \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_-\_\_\_\_

## INSURANCE INFORMATION

Name of Insured \_\_\_\_\_ Relation to Patient \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security # \_\_\_\_-\_\_\_\_-\_\_\_\_ Date Employed \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_-\_\_\_\_

Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Union/Local # \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

## ADDITIONAL INSURANCE

Name of Insured \_\_\_\_\_ Relation to Patient \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security # \_\_\_\_-\_\_\_\_-\_\_\_\_ Date Employed \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_-\_\_\_\_

Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Union/Local # \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

## MEDICAL HISTORY

Anemia ..... Yes / No	Emphysema ..... Yes / No	Pacemaker/Defibrillator .... Yes / No
Arthritis ..... Yes / No	Epilepsy ..... Yes / No	Psoriasis/Lichen planus ..... Yes / No
Artificial heart valves ..... Yes / No	Fainting ..... Yes / No	Radiation treatment ..... Yes / No
Artificial joints ..... Yes / No	Fen-Phen use ..... Yes / No	Rheumatic fever ..... Yes / No
Apnea, Obstructive sleep .... Yes / No	Glaucoma ..... Yes / No	Scarlet fever ..... Yes / No
Asthma ..... Yes / No	Headaches ..... Yes / No	Shortness of breath ..... Yes / No
Abnormal bleeding ..... Yes / No	Heart murmur ..... Yes / No	Sinus trouble ..... Yes / No
Anticoagulant therapy ..... Yes / No	Heart problems ..... Yes / No	Sickle cell anemia ..... Yes / No
Alcohol or drug abuse ..... Yes / No	Heart valve issues ..... Yes / No	Skin rash ..... Yes / No
Blood clotting disorder ..... Yes / No	Hepatitis: Type _____ ..... Yes / No	Slow healing wounds ..... Yes / No
Cancer ..... Yes / No	Herpes ..... Yes / No	Swelling of feet or ankles ... Yes / No
Alcohol / substance abuse ... Yes / No	High blood pressure ..... Yes / No	Skin ulceration ..... Yes / No
Adrenal problems ..... Yes / No	HIV ..... Yes / No	Thyroid problems ..... Yes / No
Bisphosphonate medication Yes / No	Immune deficiency ..... Yes / No	Tonsillitis ..... Yes / No
Chemotherapy ..... Yes / No	Jaundice ..... Yes / No	Tuberculosis ..... Yes / No
Circulatory problems ..... Yes / No	Liver disease ..... Yes / No	Tumor or head/neck growth. Yes / No
Congenital heart defects ..... Yes / No	Low blood pressure ..... Yes / No	Sexually transmitted disease Yes / No
Persistent cough ..... Yes / No	Kidney disease ..... Yes / No	Contact lenses ..... Yes / No
Diabetes ..... Yes / No	Osteoporosis/ Osteopenia ... Yes / No	Hearing aids ..... Yes / No

Physician's Name \_\_\_\_\_ Date of last visit \_\_\_\_\_

Have you had any serious illnesses or operations? Yes / No If Yes, describe \_\_\_\_\_

Have you ever had a blood transfusion? Yes / No If yes, give approximate dates \_\_\_\_\_

(Women) Pregnant? Yes / No Due date: \_\_\_\_\_ Nursing? Yes / No Taking birth control pills? Yes / No

List medications you are currently taking: \_\_\_\_\_

Allergies (i.e.. penicillin, aspirin, latex): Yes / No Specify: \_\_\_\_\_

Do you smoke, chew, or consume tobacco or marijuana products? Yes / No Specify: \_\_\_\_\_

## DENTAL HISTORY

Bad breath..... Yes / No	Jaw popping, pain, locking or tiredness ..... Yes / No
Blisters on lips or mouth ..... Yes / No	Lip or cheek biting ..... Yes / No
Burning sensation on tongue ..... Yes / No	Loose teeth or broken fillings ..... Yes / No
Orthodontic treatment ..... Yes / No	Mouth breathing ..... Yes / No
Food collection between the teeth ..... Yes / No	Sleep apnea ..... Yes / No
Periodontal treatment ..... Yes / No	Have you needed sedation for dental work? ... Yes / No
Clench or grind teeth ..... Yes / No	Nitrous oxide (laughing gas)? ..... Yes / No
Growths or sore spots in your mouth ..... Yes / No	Oral sedation (pills)? ..... Yes / No
Sensitivity to pressure, cold, heat, or sweets .. Yes / No	I.V. (intravenous) sedation? ..... Yes / No
Gums swollen, tender or bleeding ..... Yes / No	

**DENTAL HISTORY** (continued)

Have you ever had an allergic reaction to a local or general anesthetic? Yes / No Explain: \_\_\_\_\_

Have you had trouble from previous dental care? Yes / No Explain: \_\_\_\_\_

**AUTHORIZATION AND RELEASE**

I have read and answered the above questions to the best of my knowledge. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether paid by my insurance, or not. I authorize the use of this signature on all insurance submissions.

**Patient signature (or parent/guardian)** \_\_\_\_\_ **Date** \_\_\_\_\_