PERIODONTAL SPECIALISTS

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PATIENT INFORMATION: (PLEASE PRINT)

Today's Date: _____

Full Name: _____

Prefer to Be Called (Nickname): _____Birthdate: _____

Present/Referring Dentist's Name: _____

Email Address: _____
(Your email address will be kept private; our office uses this information to contact you regarding your appointments.)

Cell #_____ Home #_____

Preferred to be contacted by: (check all that apply) Email ☐ Cell# ☐ Home# ☐

Male ☐ Female ☐ Social Security #_____ Marital Status: _____

Address: _____ City _____ State_____ Zip _____

Mailing Address: (If different from above)

P.O. Box _____ City _____State _____ Zip _____

Employer: _____

Spouse's Name: _____ Birth date: _____ Social Security#_____

Employer: _____

RESPONSIBLE PARTY INFORMATION: SELF ☐ OTHER ☐

IF "OTHER" PLEASE COMPLETE THE FOLLOWING

Name: _____ Birth date: _____ Relationship to Patient_____

Home #_____ Cell #_____ Work# _____

Address: _____ City _____ State_____ Zip _____

Employer: _____

EMERGENCY CONTACT INFORMATION:

Name of nearest relative NOT living with you: _____ Phone#_____

DENTAL INSURANCE INFORMATION:

While we are pleased to be of service by processing your dental claim for you, we are not responsible for any limitations in coverage that may be included in your dental insurance plan. If your dental plan denies your claim for any reason, you are responsible for your bill in its entirety.

Insurance Company's Name: _____

Subscriber's Name: _____Social Security #_____

Birth date: _____ Relationship to patient: _____

Insurance Group #_____ Subscriber/Member ID #_____

Insurance Phone #_____ Subscriber's Employer: _____

Insurance Mailing Address to Submit Claims:

Address: _____ City _____ State_____ Zip _____

SECONDARY DENTAL INSURANCE INFORMATION:

Insurance Company's Name: _____

Subscriber's Name: _____Social Security #_____

Birth date: _____ Relationship to patient: _____

Insurance Group #_____ Subscriber/Member ID #_____

Insurance Phone #_____ Subscriber's Employer: _____

Insurance Mailing Address to Submit Claims:

Address: _____ City _____ State_____ Zip _____

NOTICE:
Dr. Bradshaw, Dr. Chodroff, and Dr. Todd are providers for: Blue/Cross Blue Shield, Delta Dental, Dental Select, and Select Health Dental. In addition, Dr. Todd and Dr. Chodroff are also providers for EMI, PEHP, and MetLife.

If you have a different dental insurance company we will bill them for you, but we are not contracted to their fee schedule. Your benefits and coverage will be paid differently in our office.

Authorization to Release Information
I hereby authorize any provider, Insurer, or other organization to release any information regarding the dental history, treatment, or benefits payable for this claim to the plan administrator or its authorized agent for purpose of determining benefits payable.

Patients Signature: _____ Date: _____

FINANCIAL POLICY

We provide the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care. The following is a statement of our Financial Policy to reduce confusion and misunderstanding between our patients and practice, which we require you to read and sign prior to any treatment. If you have any questions regarding these policies, please discuss them with our front desk.

IF YOU DON'T HAVE DENTAL INSURANCE:

- **Payment in full is due at the time of service**
  - ♦ Cash
  - ♦ Personal Check
  - ♦ Master Card, Visa, Discover Card, and American Express.
  - ♦ Care Credit – an extended time payment plan, that you apply for, that allows 3, 6, or 12 months at no interest to you. Please ask for more information if you are interested.

IF YOU HAVE DENTAL INSURANCE:

- **Partial payment is due at the time of service**
  - ♦20% of fee will be collected at each visit

20% is collected because we don't know how much your insurance will cover. We will bill your insurance and after insurance payment is received we will send you a statement letting you know how much was covered and how much was not covered. The remainder of your balance will be due at that time. If you disagree with your insurance company's determination, you must contact your insurance company.

A service charge of 1 ½% per month on the unpaid balance will be charged on all accounts exceeding 30 days. When accounts have exceeded 90 days we reserve the right to report the account to a collection agency. The undersigning specifically agrees to pay all reasonable attorneys' fees and court costs in the event legal action is taken to collect on the account. The undersigned further agrees to pay an additional amount representing up to 50% of the principal balance if the account is referred to a collection agency or attorney for collections.

Patients Signature: _____ Date: _____

HEALTH QUESTIONNAIRE

Physician _____

Your Age ___ Height_____ Weight _____ Mo/Year of your last medical examination

How would you describe your present health (circle one): excellent good fair poor don't know

YES NO ???

❑ ❑ ❑ Has there been any change in your general health in the past year?
❑ ❑ ❑ Have you had a serious illness, operation or hospitalization during the past five years?
If yes, please describe_____
❑ ❑ ❑ Are you taking or have you recently taken prescribed, over the counter, inhalers, or natural medications?
Please List: _____
_____
❑ ❑ ❑ Have you ever received I.V., or taken orally: Aredia, Zometa , Fosamax or any other Bisphosphonates?
❑ ❑ ❑ Have you ever taken Pondimin (fendluramine), Phen-Fen (Phentermine) or Redux (dexphenfluramine)
❑ ❑ ❑ Has your M.D. told you to take antibiotics prior to having any type of dental procedure?
❑ ❑ ❑ Are you allergic to any medications or drugs, latex, iodine? List _____
❑ ❑ ❑ Have you ever had adverse reaction to any drugs, anesthetics, sedatives, narcotics, aspirin, ibuprofen/Motrin?
❑ ❑ ❑ Have you ever had excessive bleeding that required special treatment?
❑ ❑ ❑ Have you been diagnosed as having any Immunodeficiency, Systemic Lupus, ARC or AIDS?
❑ ❑ ❑ Is there a history of diabetes in your family?
❑ ❑ ❑ Are you required, due to health, to restrict your work or activity in any way?
❑ ❑ ❑ Are you on a special or restricted diet of any kind? _____
❑ ❑ Do you use any kind of tobacco? If so how much: _____ per day, week, month
❑ ❑ Do you use any kind of alcohol? If so how much: _____ per day, week, month
❑ ❑ ❑ 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 trimester I II III ❑ I am nursing
❑ I am taking birth control pills

Check all that you may have had in the past or that currently apply to you:

❑chest pain upon exertion	❑received blood transfusion	❑sleep apnea	❑headaches
❑shortness of breath	❑impaired liver function	❑asthma	❑migraines
❑high blood pressure	❑kidney disease	❑bronchitis	❑epilepsy
❑low blood pressure	❑impaired kidney function	❑emphysema	❑seizures
❑heart valve prosthesis	❑esophageal reflux	❑sinus troubles	❑mental health problems
❑mitral valve prolapse	❑hiatal hernia	❑persistent cough	❑recurrent infections
❑congenital heart lesion	❑G.I. ulcers	❑tuberculosis	
❑rheumatic fever	❑anorexia or bulimia	❑joint replacement surgery	
❑heart murmur	❑irritable bowel syndrome	❑connective tissue disorder	
❑damaged heart value	❑colitis	❑arthritis	
❑heart arrhythmia	❑diabetes Type I II	❑recent weight loss	
❑tachycardia	❑osteoporosis	❑chronic fatigue	
❑heart surgery	❑radiation therapy	❑glaucoma	
❑cardiac pacemaker	❑chemotherapy	❑neurological disorders	❑wear contact lenses
❑hepatitis or jaundice	❑history of cancer	❑stroke	❑severely impaired vision

DO you have any disease, problem or condition not listed above? Please explain: _____

_____

_____ _____ _____
Signature of patient or legal guardian Date Reviewed by