



PERIODONTAL SPECIALISTS

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WELCOME TO OUR OFFICE. WE ARE COMMITTED TO PROVIDING THE BEST, MOST COMPREHENSIVE CARE POSSIBLE. WE ENCOURAGE YOU TO ASK QUESTIONS. PLEASE ASSIST US BY PROVIDING THE FOLLOWING INFORMATION. ALL INFORMATION IS CONFIDENTIAL AND IS RELEASED ONLY WITH YOUR CONSENT.

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: SELF OTHER IF "OTHER" PLEASE COMPLETE BELOW

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 are committed to providing you with the best possible care. To achieve this goal, we need your assistance, and your understanding of our payment and insurance submittal policy. 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.

Missed Appointments: Because of the need for appointments, we request that you call our office 24 hours before canceling or rescheduling an appointment. **OUR OFFICE POLICY IS AS FOLLOWS** If a patient does not show for an appointment, and does not call to cancel, they may be charged up to 50% of the cost of their appointment. If ongoing disregard for this policy is shown, the provider/patient relationship will be terminated and the patient may no longer be seen at our office.

REGARDLESS OF ANY INSURANCE COVERAGE, I/we may or may not have, it is my/our responsibility to pay the entire bill.

ASSIGNMENT OF INSURANCE BENEFITS I hereby assign all dental and/or surgical benefits, to private insurance, and any other health plans, to Periodontal Specialists. I understand I am financially responsible for all charges whether paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

I have read, understand, and agree to the above Financial Policy for payment of professional fees.

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