Welcome

Thank you for selecting our periodontal health care team! To help us meet your dental health care needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask, we will be happy to help.

PATIENT INFORMATION (CONFIDENTIAL)

DATE _____

☐ **Miss.** ☐ **Ms.** ☐ **Mrs.** ☐ **Mr.** ☐ **Dr.**

Name_____ **Nickname**_____

Social Security #_____ **Birthdate**_____

Address_____

City_____ **State**_____ **Zip**_____

EmailAddress_____

Home Phone_____ **Work Phone**_____ **Cell Phone**_____

Employer_____

Check Appropriate Box: ☐ **Minor** ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widowed** ☐ **Separated**

Whom may we thank for referring you? _____

Emergency Contact:_____ **Phone**_____

DENTAL INSURANCE INFORMATION

Subscriber Name:_____ **Relationship to Patient**_____

Subscriber Social Security _____ **ID#**_____ **Birthdate** _____

Employer_____ **Group#**_____

Insurance Company Name_____ **Phone #**_____

Insurance Company Address _____

IF YOU HAVE SECONDARY DENTAL INSURANCE PLEASE COMPLETE THE FOLLOWING

Subscriber Name:_____ **Relationship to Patient**_____

Subscriber Social Security _____ **ID#**_____ **Birthdate** _____

Employer_____ **Group#**_____

Insurance Company Name_____ **Phone #**_____

Insurance Company Address_____

Bruce K. Barr, D.D.S., P.C.
Kenneth W. Marinak, D.D.S.
& Associates

Diplomates of the American Board of Periodontology

PATIENT MEDICAL HISTORY

Name of Physician_____ Office Phone#_____

Pharmacy Name/Location _____ Pharmacy # _____

YES NO

☐ ☐ Are you allergic to any medications? If so, please list_____

_____

☐ ☐ Are you taking a blood thinner or aspirin daily? _____

☐ ☐ Are you required to PRE-MEDICATE with an antibiotic prior to dental procedures?

☐ ☐ Do you use tobacco?

☐ ☐ Do you drink alcohol?

☐ ☐ Are you taking any medications? If yes please list. _____

_____

☐ See attached list

Women:

☐ ☐ Are you pregnant?

☐ ☐ Are you nursing?

☐ ☐ Are you taking birth control

DO YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING?

	YES	NO		YES	NO
High Blood Pressure	☐	☐	Heart murmur/valve defect/stent	☐	☐
Pacemaker	☐	☐	Excessive bleeding	☐	☐
Bruise Easily	☐	☐	Cancer	☐	☐
Sinus Trouble	☐	☐	Arthritis	☐	☐
Asthma	☐	☐	Joint Replacement/Implant	☐	☐
Low blood pressure	☐	☐	Hepatitis	☐	☐
Epilepsy/Convulsions	☐	☐	Chest Pains	☐	☐
Anemia	☐	☐	Stroke	☐	☐
Diabetes – if yes recent HbAlc_____	☐	☐	Tuberculosis	☐	☐
AIDS or HIV infection	☐	☐	Radiation Therapy	☐	☐
Heart Disease	☐	☐	Other	☐	☐

PATIENT DENTAL HISTORY

	YES	NO		YES	NO
Do your gums bleed while brushing or flossing ?	☐	☐	Do you clinch or grind your teeth?	☐	☐
Do you feel pain in any of your teeth?	☐	☐	Have you had any orthodontic work?	☐	☐
Have you ever been told that you have gum disease?	☐	☐	Pain (joint, ear side of face)?	☐	☐
Do you have sores or lumps in or near your mouth?	☐	☐			

Please add anything you feel is important that we may assist us in treating you _____

_____

Authorization and Release

I certify that I have read and understand the above information. The above questions have been accurately answered. I understand that providing the incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payor and/or health care practitioners. I understand that I am personally, fully responsible for payment of services rendered. If dental insurance is expected to cover any part of the fees, all deductibles and co-payments will be paid by me at each visit. I understand my dental insurance carrier may pay less than the actual bill for services. I authorize and request my insurance company to pay directly to the dentist. Accounts 30 days past due are subject to a finance charge of 1.53MPR. I also understand I am responsible for all collection and/or legal fees in the event my financial arrangements are not kept, including an attorney's fee of 33% of the balance referred to the attorney, I agree to be responsible for payment of all services rendered on my behalf or dependents.

Signature of patient or parent, if minor, _____Date_____