

NEW PATIENT INFORMATION RECORD

(circle one): Mr. Dr. Mrs. Ms. Miss NAME:		REFERRED BY:	
ADDRESS:	CITY:	ZIP:	HOME TEL. NO.:
EMPLOYER:	OCCUPATION:	BUS. TEL. NO.:	
DATE OF BIRTH:	SOC. SEC. NO.:	MEDICAL DOCTOR:	PHONE:
E-MAIL ADDRESS:			
SPOUSE INFORMATION			
NAME:			
EMPLOYER:	ADDRESS:	CITY:	ZIP:
POSITION:		PHONE:	EXT.:
EMERGENCY CONTACT:		PHONE:	EXT.:

MY DENTAL INSURANCE INFORMATION
INSURANCE CO.:
POLICY NUMBER:
Date of Birth:
Social Security #:
Insurance Carrier Address:
Insurance Carrier Phone:
Employer:

MY SPOUSE'S DENTAL INSURANCE INFORMATION
INSURANCE CO.:
POLICY NUMBER:
Date of Birth:
Social Security #:
Insurance Carrier Address:
Insurance Carrier Phone:
Employer:

I AM NOT COVERED BY ANY DENTAL INSURANCE (EITHER MINE OR OTHER FAMILY MEMBER'S) AT THIS TIME.

I hereby authorize Michael Seda, D.M.D., M.S., Rachel Brinker, D.M.D., or their staff 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 Michael Seda, D.M.D., M.S. or Rachel Brinker, D.M.D. of the medical and dental insurance benefits otherwise payable to me, for the services rendered to me by either doctor or their staff. I have been informed that this office will report my diagnosis, treatment and fees to my carrier(s) in accord 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 carrier(s) 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 Michael Seda, D.M.D., M.S. or Rachel Brinker, D.M.D..

Appointments: Your appointment time is reserved for you. We will do our best to be prompt and to estimate the time of your visit, but emergencies do arise. Please allow enough time for us to do our best dentistry for you. We believe that quality is more important than speed. There is a charge for missed appointments or cancellations without 24 hours notice, 48 hours for hygiene and for surgical appointments, 72 hours is required.

Payment: I also acknowledge full responsibility for the payment of such services and agree to pay for them, in full, AT THE TIME OF SERVICE, unless other arrangements are made with the Financial Department. I further understand that a 1 1/2% finance charge (18% annually) will be added to any balance over 60 days. In the event of default I (We) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

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

Medical History

Your general health constitutes an important factor, and in combination with other causes, may influence the course of periodontal disease. To assure your health during therapy and to assist in establishing a complete diagnosis and successful treatment, please complete this confidential form.

- Would you describe your general health as good? Yes No
- Are you currently being treated by a physician? Yes No
- If so, for what condition? _____ Date of your last physical exam _____
- Are you now taking or have you been taking any drugs or medications within the last year? Yes No
- If so, please list _____
- Are you now taking or have you ever taken Bisphosphonate medications (Fosamax, etc.)? Yes No
- Have you had a major illness or been hospitalized within the last 3 years? Yes No
- If so, please describe _____
- Do you smoke or use tobacco regularly? If so, how much? _____ (Packs per day) Yes No
- Do you have any history of tobacco use? Yes No Quit date _____

Please check if you are sensitive or allergic to any of the following: _____

- | | | |
|--|---------------------------------------|---|
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Barbiturates | <input type="checkbox"/> Latex Allergy |
| <input type="checkbox"/> Other Antibiotic | (sleeping pills, sedatives) | <input type="checkbox"/> Codeine |
| <input type="checkbox"/> Novocain or other Dental Anesthetic | <input type="checkbox"/> Sulfa Drugs | <input type="checkbox"/> Aspirin |
| <input type="checkbox"/> Nitrous Oxide | <input type="checkbox"/> Demerol | <input type="checkbox"/> Natural Remedies |
| <input type="checkbox"/> Recreational Drugs | <input type="checkbox"/> Other: _____ | |

Please check if you have ever had any of the following:

- | | | |
|---|---|---|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Artificial Transplants or Implants | <input type="checkbox"/> Venereal Disease (Syphilis or Gonorrhea) |
| <input type="checkbox"/> Heart Attack | (Pacemaker, Heart Valve, Hip Joint) | <input type="checkbox"/> Severe or Frequent Headaches |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Blood Disorders | <input type="checkbox"/> Nervous Disorders/Psychiatric Care |
| <input type="checkbox"/> Heart Murmur | (Anemia, Leukemia, Hemophilia) | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Lung Disease (TB, Asthma, Emphysema) |
| <input type="checkbox"/> Abnormal Blood Pressure (high/low) | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Fainting Spells/Convulsions | <input type="checkbox"/> Skin Diseases |
| <input type="checkbox"/> Ulcers, Stomach Problems | <input type="checkbox"/> Tumors, Malignancies or Cancer | <input type="checkbox"/> Eye Disease (Glaucoma, Cataracts) |
| <input type="checkbox"/> Hepatitis, Liver Disease/Jaundice | <input type="checkbox"/> Chemotherapy Treatment | <input type="checkbox"/> Ear Trouble, Ringing in Ear, Dizziness |
| <input type="checkbox"/> Kidney Disease or Infections | <input type="checkbox"/> X-Ray, Radium or Cobalt Treatment | <input type="checkbox"/> Severe Stress |
| <input type="checkbox"/> HIV, AIDS or ARC | <input type="checkbox"/> Herpes | |

WOMEN: Are you nursing? Yes No Pregnant? Yes No Delivery Date _____

Taking oral contraceptives? Yes No

Is there any other information about your health which might be important for us to know? _____

Dental History

- Date of last cleaning _____
- Are any of your teeth sensitive to heat, cold, chewing or sweets? Yes No
- Have you ever had root planing (deep scaling) done? Yes No
- Have you ever been treated for pain in the jaw joints? Yes No
- Have you had previous periodontal surgery? Yes No
- If so, when? _____
- Are you apprehensive about dental treatment? Yes No
- Have you ever had any complications following any dental treatment? Yes No

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication.

Signature: _____ Date: _____