



MCKINNEY PERIODONTICS & IMPLANT DENTISTRY

PATIENT DEMOGRAPHIC INFORMATION

Mr. Mrs. Miss Ms. Dr. _____
Last First Middle Initial

I wish to be called at: home work other _____ Name of Spouse/Partner _____

Address _____ Apt. No. _____

City, State, Zip _____

Home Phone (____) _____ Work Phone (____) _____ Ext.# _____

Birthdate _____ Social Security # _____ - _____ - _____

Referred by _____ Your General Dentist _____
(If Different from Referral)

DENTAL INSURANCE INFORMATION

Primary Insurance

Name of Insured _____

Relationship to Patient _____

Insured's Birthdate _____

Soc. Sec. # _____ - _____ - _____

Insurance ID # _____

Employer _____

Insurance Co. _____

Insurance Address _____

Group # _____

Group Name _____

___ I am not covered by any Dental Insurance at this time

I hereby authorize David T Philofsky, DDS, MS, or his 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 David T Philofsky, DDS, MS of the medical and dental benefits otherwise payable to me, for the services rendered to me by either doctors 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 Dental Association, 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 David T Philofsky, DDS, MS.

Privacy of Information Policy: I have been informed that this practice will make reasonable effort to protect the privacy of my health information in accord with the policies set down for dental care providers under the Health Insurance Protection and Accountability Act of 1996 and have read this practice's policy statement on privacy of patient's healthcare information. I authorize the release any and all medical and dental information pertinent to my treatment to my other treating healthcare providers.

Cancellation Policy: There will be a substantial charge if a surgical treatment appointment is canceled with less than 3 working days notice. All other appointments require 1 full working day's notice for any change. Please remember this time is reserved exclusively for you. Your courtesy in doing this may allow someone else to be seen in a timelier manner.

Payment: There is a 5% discount for full payment by cash at the time services are rendered. Full payment by credit card perceives a 3% discount under the same conditions. We request that all balances be paid in full within 90 days of treatment, unless specific financial arrangements are made before treatment.

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



MCKINNEY

PERIODONTICS & IMPLANT DENTISTRY

DENTAL QUESTIONNAIRE FOR NEW PATIENT

YOUR DENTIST'S NAME _____ FOR HOW LONG: _____

HOW FREQUENTLY HAVE YOU HAD YOUR TEETH CLEANED DURING THE PAST 5 YEARS:

- LESS THAN ONCE A YEAR ONCE A YEAR TWICE A YEAR THREE TIMES A YEAR FOUR TIMES A YEAR

MO/YEAR OF YOUR LAST DENTAL EXAM _____ MO/YEAR OF YOUR LAST DENTAL X-RAYS _____

ARE YOU PRESENTLY SATISFIED WITH THE CONDITION OF YOUR MOUTH AND TEETH(CIRCLE ONE):

- VERY SATISFIED SATISFIED IT'S O.K. SOMEWHAT DISSATISFIED VERY DISSATISFIED

YES NO

- DO YOU PRESENTLY HAVE ANY PAIN, DISCOMFORT OR IMPAIRED FUNCTION RELATED TO YOUR MOUTH?
If YES, PLEASE DESCRIBE? _____
- ARE YOU CURRENTLY AWARE OF ANY INFECTION IN YOUR MOUTH?
If YES, PLEASE DESCRIBE: _____
- ARE YOU CURRENTLY TAKING ANY ANTIBIOTICS FOR INFECTION? If SO, WHAT: _____
- DO YOUR GUMS EVER BLEED? If SO, WHEN: _____
- DO YOU HAVE A PROBLEM WITH BAD BREATH OR HAVE ANY FRIENDS OR FAMILY MADE YOU AWARE OF THIS?
- ARE YOU INTERESTED IN REPLACING LOST TEETH?
- DO YOU EVER HAVE ACHES OR PAINS IN YOUR JAW JOINTS, EARS, FACE, NECK OR HEAD?
- ARE ANY OF YOUR TEETH TENDER WHEN YOU CHEW HARD FOODS?
- ARE ANY OF YOUR TEETH MORE SENSITIVE TO: COLD, HOT, SWEETS, CERTAIN FOODS OR DRINKS?
- ARE ANY PARTICULAR TEETH VERY SENSITIVE OR PAINFUL? WHEN? _____
- ARE YOU CONCERNED ABOUT GUM RECESSION AROUND ANY OF YOUR TEETH?
- ARE YOU CONCERNED ABOUT THE APPEARANCE OF YOUR TEETH OR MOUTH?
- HAVE YOU EVER HAD ORTHODONTIC TREATMENT? WITH BRACES WITH REMOVABLE APPLIANCES
WHEN DID YOU GO THROUGH ORTHODONTIC CARE? _____
- HAVE YOU EVER RECEIVED PERIODONTAL TREATMENT? SCALING/ROOT PLANING GUM SURGERY
WHEN DID YOU GO THROUGH PERIODONTAL CARE? _____

CHECK ANY OF THE FOLLOWING THAT DESCRIBE YOU OR MAKES DENTAL TREATMENT EASIER FOR YOU:

- I TOLERATE MOST DENTAL CARE REASONABLY WELL AND USUALLY REQUIRE MINIMAL USE OF ANESTHESIA
- I APPRECIATE THE USE OF LOCAL ANESTHETIC – IT ALLOWS ME TO TOLERATE MOST DENTAL CARE REASONABLY WELL
- I TOLERATE SHOTS IN MY MOUTH WHEN THEY ARE GIVEN WELL
- I LIKE THE BENEFITS OF NITROUS OXIDE (LAUGHING GAS)
- I PREFER TO BE SEDATED FOR ANY SURGICAL TREATMENT
- I PREFER TO BE SEDATED FOR ANY LENGTHY SURGICAL CARE
- I HAVE A HARD TIME SITTING IN THE DENTAL CHAIR FOR MORE THAN AN HOUR
- I HAVE A HARD TIME SITTING IN THE DENTAL CHAIR VERY LONG DUE TO A NECK, BACK, SPINE PROBLEM
- I HAVE DIFFICULTY WHEN TILTED BACK IN THE DENTAL CHAIR (DIZZINESS, BREATHING DIFFICULTY, _____)

WHAT ARE YOUR GOALS OR PRIORITIES FOR THE HEALTH, FUNCTION AND APPEARANCE OF YOUR TEETH & MOUTH:

(RATE EACH ITEM FROM 1 TO 5 WITH 1 BEING YOUR LOWEST PRIORITY AND 5 YOUR HIGHEST – YOU CAN USE ANY NUMBER MORE THAN ONCE)

- | | |
|-----------------------------------------------|--------------------------------------------|
| ___ BE ABLE TO CHEW FOOD AND EAT WHAT I ENJOY | ___ AVOID REMOVABLE BRIDGEWORK |
| ___ PRESERVE MY TEETH & AVOID DENTURES | ___ FOR MY MOUTH TO LOOK NICE WHEN I SMILE |
| ___ BE FREE OF INFECTION | ___ MAKE MY TEETH LOOK GOOD |
| ___ BE FREE OF MOUTH PAIN & TENDERNESS | ___ HAVE A HEALTHY AND HASSLE-FREE MOUTH |

Signature of patient or legal guardian _____

Date _____

Reviewed by _____



MCKINNEY PERIODONTICS & IMPLANT DENTISTRY

HEALTH QUESTIONNAIRE FOR NEW PATIENT

PHYSICIAN _____ Your HMO I.D. # _____

ADDRESS _____ CITY _____ PHONE _____

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?
IF YES, PLEASE DESCRIBE _____

HAVE YOU HAD A SERIOUS ILLNESS, OPERATION OR HOSPITALIZATION DURING THE PAST FIVE YEARS?
IF YES, PLEASE DESCRIBE _____

ARE YOU TAKING ANY OVER THE COUNTER OR PRESCRIPTION MEDICATIONS AT THIS TIME?
IF YES, 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) FOR WEIGHT REDUCTION?

DO YOU REQUIRE PRE-MEDICATION FOR DENTAL TREATMENT DUE TO ARTIFICIAL JOINTS OR HEART?

ARE YOU ALLERGIC TO ANY MEDICATIONS OR LATEX?
IF YES, PLEASE LIST _____

HAVE YOU EVER HAD ADVERSE REACTION TO ANY DRUGS AND OR ANESETHETICS
IF YES, PLEASE LIST _____

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 I AM NURSING I AM TAKING BIRTH CONTROL PILLS

CHECK ALL OF THE FOLLOWING 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 BLOODTRANSFUSION | <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"/> ESOPHYGEAL 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"/> CONGENITAL HEART LESION | <input type="checkbox"/> G.I. ULCERS | <input type="checkbox"/> TUBERCULOSIS | <input type="checkbox"/> GLAUCOMA |
| <input type="checkbox"/> RHEUMATIC FEVER | <input type="checkbox"/> ANOREXIA OR BULEMIA | | <input type="checkbox"/> WEAR CONTACT LENSES |
| <input type="checkbox"/> HEART MURMUR | <input type="checkbox"/> IRRITABLE BOWEL SYNDROME | <input type="checkbox"/> JOINT REPLACEMENT SURGERY | <input type="checkbox"/> SEVERELY IMPAIRED VISION |
| <input type="checkbox"/> DAMAGED HEART VALUE | <input type="checkbox"/> COLITIS | <input type="checkbox"/> ARTHRITIS | |
| <input type="checkbox"/> HEART ARRHYTHMIA | <input type="checkbox"/> DIABETES | <input type="checkbox"/> CONNECTIVE TISSUE DISORDER | <input type="checkbox"/> RECURRENT INFECTIONS |
| <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"/> RECENT WEIGHT LOSS |
| <input type="checkbox"/> CARDIAC PACEMAKER | <input type="checkbox"/> CHEMOTHERAPY | <input type="checkbox"/> NEUROLOGICAL DISORDERS | |
| <input type="checkbox"/> HEPATITIS OR JAUNDICE | <input type="checkbox"/> HISTORY OF CANCER | <input type="checkbox"/> STROKE | |

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

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