



**Golden Triangle Periodontal Center**  
*Periodontal Therapy, Dental Implants*  
**Oral Health Questionnaire**

Social Security No. \_\_\_\_\_ Date \_\_\_\_\_ Date of Birth \_\_\_\_\_

Name \_\_\_\_\_ Phone (H) \_\_\_\_\_  
 Last First Middle (O) \_\_\_\_\_ EXT \_\_\_\_\_  
 (Cell) \_\_\_\_\_

Address \_\_\_\_\_ Zip \_\_\_\_\_  
 City State

If P.O. Box please provide physical address \_\_\_\_\_ email \_\_\_\_\_

Single  Married  Separated  Divorced  Widowed SEX  M  F Wt. \_\_\_\_\_ Ht. \_\_\_\_\_

Business Address \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

**Spouse or Responsible Party Information**

Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Employer \_\_\_\_\_ Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_

**Health Information**

Referred by \_\_\_\_\_ Name of your Dentist \_\_\_\_\_

Name of Physician \_\_\_\_\_ Address \_\_\_\_\_

Present Medications you are taking:  
 1) \_\_\_\_\_ 2) \_\_\_\_\_ 3.) \_\_\_\_\_ 4) \_\_\_\_\_

- Have you ever had complications following dental treatment? \_\_\_\_\_  
 If yes, please explain: \_\_\_\_\_
- Are you now under the care of a physician? \_\_\_\_\_  
 If yes, please explain: \_\_\_\_\_
- Do you have any health problems that need further clarification? \_\_\_\_\_  
 If yes, please explain: \_\_\_\_\_

Please check those that apply:

- |   |   |  |   |
|---|---|--|---|
| <input type="checkbox"/> AIDS                     | <input type="checkbox"/> Low blood pressure         | <input type="checkbox"/> Liver Disease           | <input type="checkbox"/> Stroke                 |
| <input type="checkbox"/> Allergies _____          | <input type="checkbox"/> Taking birth control pills | <input type="checkbox"/> Clicking/popping of jaw | <input type="checkbox"/> Tuberculosis           |
| <input type="checkbox"/> Local Anesthesia         | <input type="checkbox"/> Anticoagulant drugs        | <input type="checkbox"/> Nervous Disorders       | <input type="checkbox"/> Tumors                 |
| <input type="checkbox"/> Arthritis                | <input type="checkbox"/> Cortisone                  | <input type="checkbox"/> Pacemaker               | <input type="checkbox"/> Lung Disease           |
| <input type="checkbox"/> General Anesthesia       | <input type="checkbox"/> Novocain Sensitivity       | <input type="checkbox"/> Pregnancy               | <input type="checkbox"/> Swelling of hands/feet |
| <input type="checkbox"/> Blood Disease            | <input type="checkbox"/> Head Injuries              | Due Date: _____                                  | <input type="checkbox"/> Codeine Allergy        |
| <input type="checkbox"/> Epilepsy or convulsions  | <input type="checkbox"/> Heart Disease              | <input type="checkbox"/> Radiation Treatment     | <input type="checkbox"/> Penicillin Allergy     |
| <input type="checkbox"/> Diabetes                 | <input type="checkbox"/> Heart Murmur               | <input type="checkbox"/> Respiratory Problems    | <input type="checkbox"/> Sleep Apnea            |
| <input type="checkbox"/> Dizziness, Fainting      | <input type="checkbox"/> High blood pressure        | <input type="checkbox"/> Rheumatic Fever         | <input type="checkbox"/> Other Drug Allergies   |
| <input type="checkbox"/> Shortness of Breath      | <input type="checkbox"/> Do you smoke               | <input type="checkbox"/> Sinus Problems          | _____   |
| <input type="checkbox"/> Dental work in past year | <input type="checkbox"/> Kidney Disease             | <input type="checkbox"/> Stomach Problems        | _____   |
|   | <input type="checkbox"/> Asthma                     | <input type="checkbox"/> Hepatitis               | _____   |

In case of an emergency call: \_\_\_\_\_  
 Telephone \_\_\_\_\_

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor) \_\_\_\_\_

**(SEE NEXT PAGE)**

## Dental Insurance Information

### Primary

Name of Insured: \_\_\_\_\_ Is insured a patient?  Yes  No

Insured's Birth Date \_\_\_\_\_ SS# \_\_\_\_\_ Group # \_\_\_\_\_  
Last First MI

Insured's Address: \_\_\_\_\_  
Street City State Zip Code

Insured's Employer Name: \_\_\_\_\_

Patient's relationship to insured:  Self  Spouse  Child  Other \_\_\_\_\_

Insurance Plan Name and Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Secondary

Name of Insured: \_\_\_\_\_ Is insured a patient?  Yes  No

Insured's Birth Date: \_\_\_\_\_ SS# \_\_\_\_\_ Group # \_\_\_\_\_  
Last First MI

Insured's Address: \_\_\_\_\_  
Street City State Zip Code

Insured's Employer Name: \_\_\_\_\_

Patient's relationship to insured:  Self  Spouse  Child  Other \_\_\_\_\_

Insurance Plan Name and Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 90 days, unless previously written financial arrangements are satisfied. I understand that fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

We accept Visa, MasterCard, American Express, Discover, CareCredit, cash or your person check. Please note that there will be a \$40.00 fee for any returned checks.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that until my accounts are finally settled, I give my direct consent to receive communications regarding my accounts from any collectors of my accounts, through regarding my accounts from any servicers and any collectors of my accounts, through various means such as 1) any cell, landline, or text number that I provide, 2) any email address I provide, 3) auto dialer systems, 4) voicemail messages, and other forms of communications. The reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be institute hereunder.

I grant my permission to you or your assignee, to telephone me at home, on cell, or at my work or email to discuss matters related to this form.

I understand if an appointment is broken without a 48-hour notice for the hygienist I may incur a charge of \$50/hour and for the doctor a \$100/hour.

By signing I am acknowledging that I have this office's **Notice of Privacy Practices**. I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, exam and test results, diagnosis, treatment, and any plans for future care.

I have read the above conditions of treatment and agree to their content.

Signature of patient, parent or guardian \_\_\_\_\_ Date: \_\_\_\_\_ Relationship to Patient \_\_\_\_\_