Periodontal & Implant Solutions LLC
M. George Ayad D.D.S., Ph.D.
Diplomate, American Board of Periodontology

Welcome to Periodontal & Implant Solutions. Our mission is to provide the very highest level of care in a supportive and tranquil environment. Please let us know if there is anything we can do to make your visit more comfortable and enjoyable.

Date_____

Patient Information

Last Name_____**First Name**_____**M.I.**___ **Preferred Name**_____

☐Mr. ☐Mrs. ☐Ms. ☐Dr. ☐Other_____ ☐Male ☐Female ☐Single ☐Married ☐Other ☐Child

Date of Birth_____**Social Security Number**_____

Street Address_____**Apt./Unit No.**_____

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

Email Address_____

Home Phone_____**Work Phone**_____**Ext.**_____

Fax _____**Cell/Pager**_____**Best Time to Call**_____

Health Information

Allergies (to medications, food, latex, etc.)_____

Medications (List all medications and supplements you are taking)

_____

_____

_____

Do you need to Pre-medicate? ☐Amoxicillin ☐Clindamycin ☐Other_____

Do you have, or have you had, any of the following? (Please check all that apply)

☐Auto-Immune Dysfunction	☐Diabetes	☐High Blood Pressure	☐Radiation Treatment
☐Anemia	☐Dizziness	☐HIV/AIDS	☐Respiratory Problems
☐Arthritis	☐Epilepsy	☐Jaundice	☐Rheumatic Fever
☐Artificial Joints	☐Excessive Bleeding	☐Kidney Disease	☐Rheumatism
☐Asthma	☐Fainting	☐Liver Disease	☐Sinus Problems
☐Blood Disease	☐Glaucoma	☐Mental Disorders	☐Stroke
☐Cancer	☐Growths	☐Mitral Valve Prolapse	☐Tuberculosis
☐Canker Sores	☐Hay Fever	☐Nervous Disorders	☐Tumors
☐Chemotherapy	☐Head Injuries	☐Other_____	☐Ulcers
☐Clotting Problems	☐Heart Murmur	☐Pacemaker	
☐ Cold Sore/Fever Blister	☐Hepatitis	☐Pregnancy Due Date_____	

Periodontal Risk Assessment (Please answer "Y" or "N" as applies)

___Do you smoke? If yes, how many packs/day?_____For how many years?_____= _____pack-yrs.

___Do you or any of your blood relatives have diabetes? If yes, who? _____
If yes, what type? 1___ or 2___ Approximate Date of Diagnosis_____

___Have you ever been treated for periodontal disease before? If yes, when? _____

___Do you have a family history of periodontal disease? What was done if known? _____

___Do you have a history of cardiovascular disease in your family (heart attack or stroke)?

___Have you had a bone density scan? Date_____Findings_____

___Have you ever been diagnosed with osteopenia or osteoporosis?

Contact Information

Employer

- Company Name_____
- Street Address_____Suite/Floor No._____
- City_____State_____ZipCode_____
- Phone_____

Physician

- Name_____Town_____Phone_____

Emergency Contact

- Name_____Relationship_____Phone_____

Pharmacy

- Name_____Town _____ ____Phone_____

Referred by

- Name: _____Town_____Phone_____

Dentist (If Other Than "Referred By" Above)

- Name_____Town _____Phone_____

DENTAL INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE:

- **Subscriber Name**_____**Subscriber Employer / Group Plan**_____
- **Subscriber ID No.**_____
- **Primary Insurance Carrier Name**_____
- **Street Address/PO BOX No.**_____**Suite/Floor No.**_____
- **City**_____**State**_____**ZipCode**_____
- **Phone**_____**Group No.**_____

Relationship to Subscriber: ☐ Self ☐ Spouse ☐Child ☐Other

Subscriber Information (if other than Self):

Name_____ **Date of Birth**_____**SSN**_____

- **Street Address**_____**Apt. No.**_____
- **City**_____**State**_____**ZipCode**_____
- **HomePhone**_____**Work Phone**_____
- **Employer**_____**Employer Phone**_____
- **Employer Street Address/PO Box**_____**Suite/Floor No.**_____
- **City**_____**State**_____**ZipCode**_____

……..

SECONDARY DENTAL INSURANCE:

- **Subscriber Name:** _____**Subscriber Employer / Group Plan:** _____
- **Subscriber ID #:** _____
- **Secondary Insurance Carrier Name:** _____
- **Street Address/PO BOX No.**_____**Suite/Floor No.**_____
- **City**_____**State**_____**ZipCode**_____
- **Phone**_____**Group #**_____
- **Relationship to Subscriber: ☐ Self ☐ Spouse ☐Child ☐Other**

Subscriber Information (if other than Self):

Name_____ **Date of Birth**_____**SSN**_____

- **Street Address**_____**Apt. No.**_____
- **City**_____**State**_____**ZipCode**_____
- **HomePhone**_____**Work Phone**_____
- **Employer**_____**Employer Phone**_____
- **Employer Street Address/PO Box**_____**Suite/Floor No.**_____
- **City**_____**State**_____**ZipCode**_____

Authorization to Release Information to Insurance Companies

I, _____, hereby authorize Dr. M. George Ayad and/or any of his authorized providers to provide my insurance companies and claim administrators information concerning periodontal health care, advice, treatment, or supplies provide. This information will be used exclusively for the purpose of evaluation and administering claims for benefits.

_____ _____

Patient or Authorized Guardian's Signature **Date**

_____

Please Print Patient or Guardian Name

OUR FINANCIAL POLICY

Although your dental insurance coverage does not affect your financial arrangement with us, our office is happy to submit your dental claim forms. Please keep in mind that your insurance is your benefit. Your insurance carrier will ultimately decide on the benefit to be released to you. Therefore, when making a dental care decision, it is your responsibility to know what your dental benefit will be. YOUR PAYMENT IS REQUIRED AT THE TIME OF SERVICE.

If you would like us to process your claim, simply provide us with the necessary information and sign the waiver on page 3 to allow us to release pertinent treatment information. Although we are happy to assist, YOU ARE ULTIMATELY RESPONSIBLE FOR KNOWING AND UNDERSTANDING THE LIMITS OF YOUR INSURANCE COVERAGE. Although unpleasant, there are instances where delinquent accounts must be turned over to a collection agency for payment. If this happens, you will be responsible to pay a 30% service fee on the outstanding balance.

Payment for the initial consultation is $157.00. If x-rays are taken, there will be an additional fee. A detailed treatment plan will be presented to you after the consultation, and payment options will also be indicated. If you have any questions or concerns at this point our patient care coordinator will be happy to help you now. If you do not have any questions, and understand and accept all of the above, please sign below.

_____ _____

Patient or Authorized Guardian's Signature **Date**

_____

Please Print Patient or Guardian Name

FOR OFFICE USE ONLY

DATE_____**BP**_____**P**_____**R**_____

□**PP** □**FP** **UP** □**IN** □**CFCL** □**CFOT**

UPDATE MEDICAL HISTORY

Have there been any changes in your medical history or insurance information since your last dental visit? Heart or blood problems, infectious diseases, operations, hospitalizations, pregnancy, allergies, changes in medication? Other?

No___Yes___, please explain_____
Signature_____**Date**_____/_____/_____

No___Yes___, please explain_____
Signature_____**Date**_____/_____/_____

No___Yes___, please explain_____
Signature_____**Date**_____/_____/_____

No___Yes___, please explain_____
Signature_____**Date**_____/_____/_____

No___Yes___, please explain_____
Signature_____**Date**_____/_____/_____

No___Yes___, please explain_____
Signature_____**Date**_____/_____/_____

No___Yes___, please explain_____
Signature_____**Date**_____/_____/_____

No___Yes___, please explain_____
Signature_____**Date**_____/_____/_____