PERIO PLLC

PATIENT INFORMATION

Name: _____
LAST FIRST MIDDLE INITIAL

Address: _____
STREET CITY STATE ZIP

Phone: HOME (_____) _____ Social Security #: _____

MOBILE (_____) _____ Date of Birth: _____ ☐ Male ☐ Female

WORK (_____) _____ Email: _____

May we contact you at work? ☐ *Yes* ☐ *No* *May we e-mail appointment confirmation?* ☐ *Yes* ☐ *No*

Employer: _____ Job Title:_____

Emergency Contact: _____ (_____) _____

INSURANCE

PRIMARY DENTAL CARRIER

Subscriber Name: _____ Relation to Patient: _____

Employer: _____ Date of Birth: _____

Insurance Company and Address: _____

Insurance ID or SS #: _____ Group #: _____

SECONDARY DENTAL CARRIER

Subscriber Name: _____ Relation to Patient: _____

Employer: _____ Date of Birth: _____

Insurance Company and Address: _____

Insurance ID or SS #: _____ Group #: _____

INSURANCE AUTHORIZATION STATEMENT (Sign & Date)

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs and dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history is correct to the best of knowledge.

Signature: _____ Date: _____

PERIO PLLC

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT (Sign & Date)

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physical certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Signature: _____ Date: _____

INSURANCE & PAYMENT OPTIONS (Sign & Date)

The cost of periodontal treatment varies depending upon your needs. After Dr. Remien has examined you and determined the appropriate treatment, he will provide you with an estimate of the cost. If you have dental benefits, your carrier may cover some or all of your costs. Prior to proceeding with the treatment, fees and financial arrangements will be discussed with you so that you can make an informed decision and plan accordingly.

As a courtesy to you, we will bill your insurance company and do all that we can to help you maximize any insurance benefit that you have. We view dental insurance as a "bonus" benefit that many patients unfortunately don't have. It should not dictate the type of treatment we offer nor should it dictate the type of treatment you choose to proceed with. Ultimately, services and treatment rendered you are your financial obligation and you, not your insurance company, will be held responsible for such.

For your convenience we accept Visa, MasterCard, and Discover credit cards. While we are unable to provide financing for care, we do work with CareCredit™ and Wells Fargo to offer financing options.

Signature: _____ Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment on this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Reason: _____ *Initial and Date:* _____

3817 Stephens Ave. | Missoula, MT 59801 | **T** (406) 728-8910 | **F** (866) 387-8689 | www.periopc.com

Date: _____

Name _____

Age _____

Referring Dentist _____

Yes No 1. Are you in good health?

2. Year of your last physical exam? _____

Yes No 3. Are you being treated for any condition by a physician now?

If so, what? _____

Name of Physician _____

Yes No 4. Do you take any pills, drugs or medicines?

If so, what? _____

Yes No 5. Have you been treated with bisphosphonates for osteoporosis, osteopenia, or in conjunction with cancer therapy?

If so, what? _____

Yes No 6. Are there any medicines that you are allergic to or cannot take?

If so, what? _____

Yes No 7. Have you experienced an unusual reaction to a local anesthetic (novocaine)?

Yes No 8. Have you been hospitalized or had a serious illness within the past 5 years?

If so, what? _____

9. Please check the following items which you have or have had ...

___ Anemia
___ Face or Jaw Injury
___ Ulcers
___ Allergy
___ Hives or Skin Rash
___ Asthma / Emphysema
___ Hay Fever
___ Sinus Trouble
___ Cancer
___ Artificial Joints
___ Excessive Bleeding
___ Bruise Easily
___ Angina Pectoris
___ Heart Disease
___ Heart Attack
___ Artificial Heart Valve
___ Epilepsy or Seizures
___ Fainting, Dizziness

___ Rheumatic / Scarlet Fever
___ Stroke
___ High / Low Blood Pressure
___ Diabetes
___ Kidney Trouble
___ Bladder Trouble
___ Hepatitis / Liver Trouble
___ Jaundice
___ Glaucoma
___ Venereal Disease
___ Tuberculosis
___ Lung Trouble
___ Psychiatric Treatment
___ Severe Headaches
___ Heart Murmur
___ HIV Positive
___ Drug Addiction
___ Alcoholism
___ Tobacco Use

(Continued On Back)

Yes No 10. Have you had abnormal bleeding problems associated with extractions or surgery?

Yes No 11. Have you had any serious trouble associated with any past dental treatment?
If so, explain _____

Yes No 12. Do you want to keep your remaining teeth?

Yes No 13. Do you like your smile?

Yes No 14. Are your teeth sensitive to cold, hot or sweets?

Yes No 15. Do your gums ever bleed?

Yes No 16. Have you noticed any bad odors or tastes from your mouth?

Yes No 17. Does your jaw click when you chew?

Yes No 18. Do you ever have pain in the region in front of your ears?

Yes No 19. Do you clench, grit or grind your teeth in the daytime or when you are sleeping?

Yes No 20. Have you been under more than average nervous tension lately?

Yes No 21. Do you use sugar in coffee, breath mints, lifesavers, soft drinks, Tums, Rolaids, gum, candy, dried fruits, or other sweets daily or routinely?
Which? _____

Yes No 22. Is there any health information which was not asked that you feel may influence your dental treatment?
What? _____

<u>WOMAN</u>

Yes No Are you pregnant?

Yes No Do you have any problems associated with your menstrual period?

Yes No Have you passed menopause?

PATIENT SIGNATURE (or Parent/Guardian): _____

Reviewed by
Doctor _____ Date _____ BP _____

History review and significant findings: _____
_____
_____
_____
_____
_____