SACRAMENTO PERIODONTICS

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PATIENT HEALTH HISTORY FORM

Patient Name _____

Preferred Name _____

Patient Height _____ Patient Weight _____

Dentist Name _____

Dentist Phone _____

Physician Name _____

Physician Phone _____

Preferred Pharmacy _____

Pharmacy Location _____

Do you have or have you had any of the following health conditions?

1	Heart Murmur / Mitral Valve Prolapse	☐	Yes | No ☐
2	High Blood Pressure	☐	Yes | No ☐
3	Heart Attack	☐	Yes | No ☐
4	Palpitation / Arrhythmias	☐	Yes | No ☐
5	Rheumatic Fever / Rheumatic Heart Disease	☐	Yes | No ☐
6	Bacterial Endocarditis	☐	Yes | No ☐
7	Heart Pacemaker	☐	Yes | No ☐
8	Congestive Heart Failure	☐	Yes | No ☐
9	Angina or Chest Pain	☐	Yes | No ☐

10	Open Heart Surgery		Yes | No	
11	Artificial Limb, Joint, or Valve		Yes | No	
12	Stroke		Yes | No	
13	Asthma		Yes | No	
14	Emphysema		Yes | No	
15	Tuberculosis / Lung Disease		Yes | No	
16	Blood Disorder: Anemia / Hemophilia / Sickle Cell		Yes | No	
17	HIV / ARC / AIDS		Yes | No	
18	Kidney Disease		Yes | No	
19	Jaundice / Hepatitis / Liver Disease		Yes | No	
20	Hiatal Hernia		Yes | No	
21	Stomach or Intestinal Problems / Ulcers / Colitis		Yes | No	
22	Thyroid Disease		Yes | No	
23	Diabetes		Yes | No	
	If you have diabetes, what is your A1C or sugar levels?			
24	Cancer or Cancer Treatments (Radiation or Chemotherapy)		Yes | No	
25	Fainting Spells / Seizures /Epilepsy		Yes | No	
26	Sinus Trouble		Yes | No	
27	Recent Cold or Flu		Yes | No	
28	Arthritis		Yes | No	
29	TMJ (Temporomandibular Joint Disorder)		Yes | No	
30	Psychiatric Disorders (Including Anxiety and/or Depression)		Yes | No	
31	Drug or Alcohol Addiction		Yes | No	
32	Do you or have you used recreational drugs (e.g. Cocaine, Opiates, etc.)?		Yes | No	
33	Do you currently smoke or chew tobacco?		Yes | No	
34	Have you smoked or chewed tobacco in the past?		Yes | No	
35	Do you drink any alcohol (Including Beer & Wine)?		Yes | No	
36	Do you or have you used Fen-Phen or Redux medication?		Yes | No	
37	Do you or have you ever taken oral or intravenous (IV) Bisphosphonates / Fosamax?		Yes | No	
38	Are your gums sore or swollen?		Yes | No	
39	Do your gums bleed?		Yes | No	
	When do your gums bleed?			
40	Do you have an unpleasant taste or odor in your mouth?		Yes | No	

41	Are your teeth sensitive to cold or hot temperatures?	☐ Yes | No ☐
42	Do you have ongoing treatment with your General Dentist?	☐ Yes | No ☐
43	Do you or have you had Orthodontic Treatment (e.g. Braces or Invisalign)?	☐ Yes | No ☐
44	Do you wear a Retainer, NightGuard, or Dentures?	☐ Yes | No ☐
45	Have you had a history of Periodontal Treatment (including deep cleaning)?	☐ Yes | No ☐
46	Do you require Premedication, such as Antibiotics prior to any dental treatment?	☐ Yes | No ☐

Any Dental Complaint?

List any previous surgeries or hospitalization:

Provide a list of all prescriptions, over-the-counter, or herbal medications you are currently taking, including the dosage:

List any allergies (e.g. latex, anesthetics, aspirins, penicillin, codeine, fluoride, iodine):

I, the undersigned, being the patient, parent, or guardian do state that the above information is accurate to the best of my knowledge and I hereby consent to any diagnostic procedures considered valuable by the doctor.

Patient Name (Please Print)

Patient Date of Birth

Patient Signature

Today's Date

PATIENT INFORMATION FORM

Patient Information:

Name: _____ Sex: _____

Age: _____ Date of Birth: _____

Social Security #: _____ Driver's License #: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Work: _____

Email: _____ Employer: _____

Emergency Contact Name: _____

Emergency Contact's Relationship to Patient: _____

Emergency Contact Phone: _____

Primary Dental Insurance:

Name of Subscriber: _____

Subscriber DOB: _____ Subscriber SS #: _____

Subscriber's Relationship to Patient: _____

Insurance Company: _____ Employer: _____

Insurance Contact #: _____ Group #: _____

Insurance Address: _____

Secondary Dental Insurance:

Name of Subscriber: _____

Subscriber DOB: _____ Subscriber SS #: _____

Subscriber's Relationship to Patient: _____

Insurance Company: _____ Employer: _____

Insurance Contact #: _____ Group #: _____

Insurance Address: _____

Who is financially responsible for your account (if different than patient)?

Name: _____ DOB: _____

SS #: _____ Driver's License #: _____

Home Phone: _____ Cell: _____ Work: _____

Address: _____

City: _____ State: _____ Zip: _____

Financial Responsibility Agreement

I understand that I am responsible for all fees and that this office will bill my insurance as a courtesy to me. If my insurance does not pay within (60) days of submission, I understand that I will be solely responsible for any balance due. I agree to notify you of any changes in my health status or any changes in the above information.

Signature: _____ Date: _____

OFFICE POLICIES

General Information

All charges are the direct responsibility of the patient or parent/guardian, and payment is due on the day of services rendered unless other financial arrangements are made. We do accept Mastercard or Visa as a method of payment. All balances more than 60 days overdue are subject to a 1.5% finance fee. All returned checks are subject to a $25 returned check fee.

Initial _____

Cancellation of Appointments

Due to the length of periodontal appointments, we require a minimum of 48 hours' notice if canceling or rescheduling. A charge of $250 may apply if proper notice is not given.

Initial _____

Insurance Patients

Acceptance of insurance assignments by this office does not absolve the patient of responsibility for charges in full for treatment rendered. The estimate provided by this office is to be considered a guideline until the final insurance payment is received and the patient's account has been reconciled. Please note: All charges are the direct responsibility of the patient. For your convenience, we prepare and submit the necessary reports to the insurance companies, provided we have accurate information. If we're able to verify coverage, all fees are due and payable on the day of the surgery or treatment. If we do not receive payment from your insurance within 60 days of the submission of your claim, you will be responsible for payment of the entire fee at that time. A monthly finance fee of 1.5% will also be charged until the account is paid.

Initial _____

Assignment of Insurance Benefits

Authorization to pay Doctor: I hereby authorize payment directly to Dr. Shaunda Thomas and Sacramento Periodontics for any such benefits otherwise payable to me. I understand I am financially responsible to the doctor for charges not covered by this authorization.

Initial _____

Authorization to Release Information

I hereby authorize Dr. Shaunda Thomas and Sacramento Periodontics to release information acquired in the course of my examination and treatment to my insurance company(s).

Initial _____

Authorize Use of Photographs & Waivers

Dr. Shaunda Thomas and Sacramento Periodontics have photographs of your mouth, which demonstrate the results of the periodontal work you have received. By signing below, you authorize Dr. Shaunda Thomas and Sacramento Periodontics to use the photographs for the limited purpose of explaining, depicting, and/or promoting to dentists, patients, and potential patients the results that can be obtained following the sort of periodontal surgery or treatment performed on you. You agree to waive your right of privacy with regards to the photographs for the limited purpose only and waive any right you might have to compensation for the use of the photographs.

Initial _____

Notice of Privacy Practices

In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), please be advised that this office will bill you or your insurance company directly for services using the United States Postal Service. Your medical account information is considered personal and confidential and is accessible only by authorized personnel.

Initial _____

I acknowledge that I have read and understand the paragraphs on this page and the preceding page (Office Policies).

Signature: _____ Date: _____