Eastside Periodontics

Introduction & Health History

INTRODUCTIONS

Patient Name _____ Preferred Name _____SS#_____

Address _____City/State/Zip_____

Phone - H_____ W_____Cell _____

Birth date _____ How would you like to be reminded of appointments? Phone ☐ Email ☐ Text ☐

Email _____ Marital Status: Married ☐ Single ☐ Widowed ☐ Partner/significant other ☐

Employer _____Job title? _____

Emergency Contact _____ Relationship _____ Phone _____

Primary <u>DENTAL</u> Insurance Coverage

Insured Name (if different than patient) _____

Insurance Co. Name_____

Group # _____ Member ID# # _____

Birth date _____ SS# _____ - _____ - _____

Employer_____

Secondary **<u>DENTAL</u>** Insurance Coverage

Insured Name (if different than patient) _____

Insurance Co. Name_____

Group # _____ Member ID# # _____

Birth date _____ SS# _____ - _____ - _____

Employer_____

ACKNOWLEDGMENT AND RELEASE

To the best of my knowledge the above information is correct. I will inform this office of any changes.

I **Consent** to dental and periodontal treatment by Dr. Likhari and the taking of photographs and X-rays before, during, and after treatment and to the use of the same by the doctor in scientific presentations or publications.

Financial agreement: Our full payment policy will be provided at the end of your initial visit along with the proposed treatment and fees. We are PPO providers of WDS, Delta Dental Groups and Cigna.

Signature _____ Date _____

(Parent or guardian if patient is a minor)

<u>GETTING TO KNOW YOU</u>

! Have you had problems or undesirable experiences with previous dental treatment? _____

_____

! What can we do to make you feel comfortable (**Nitrous oxide/laughing gas, Music, Other**)?_____

_____

MEDICAL HISTORY

- Are you under the care of a healthcare provider? No ☐ Yes ☐ May we consult with them? No ☐ Yes ☐
- **Doctor's name and phone number**? _____
- Have you been a patient in the hospital in the last two years? No ☐ Yes ☐
  If so explain_____
- Do you use any **tobacco** products? No ☐ Yes ☐
  Type of tobacco product_____How much per day _____For how long_____

WOMEN: Are you **pregnant**? No ☐ Yes ☐ Month due? _____ Are you **nursing**? No ☐ Yes ☐
Are you taking **birth control pills**? No ☐ Yes ☐
Have you gone through menopause? No ☐ Yes ☐

PLEASE MARK PAST AND PRESENT CONDITIONS:

☐ Anemia	☐ Depression or Anxiety	☐ Hepatitis A, B, or C	☐ Osteopenia
☐ Angina	☐ **Diabetes**	☐ **High Blood Pressure**	☐ Pacemaker
☐ Arthritis	☐ Diabetes in Family	☐ **Low Blood Pressure**	☐ Radiation Therapy
☐ Artificial Heart Valve	☐ Drug or Alcohol Abuse	☐ HIV Positive or AIDS	☐ **Rheumatic Fever or Scarlet Fever**
☐ **Artificial Joints**	☐ Epilepsy	☐ Jaundice	☐ Sinus Trouble
☐ Asthma	☐ Fainting or Dizzy Spells	☐ Jaw Joint Pain	☐ Skin Rash or Hives
☐ Bleeding Disorders	☐ Glaucoma	☐ Kidney Disease, ☐ Lupus	☐ Stroke
☐ Cancer or Cancer Treatment	☐ Hay Fever	☐ **Mitral Valve Prolapse**	☐ Thyroid Disease
☐ Chemotherapy	☐ Seasonal Allergies	☐ Numbness or Tingling Sensations	☐ Tuberculosis
☐ Chronic Cough	☐ Heart Disease or Attack/surgery	☐ Osteoporosis	☐ Ulcers
☐ Cold Sores	☐ **Heart Murmur**		
☐ Cortisone Therapy			
☐ Cosmetic Surgery			

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

☐ Aspirin	☐ Local Anesthetics (Novocain)	☐ Other _____
☐ Anti Inflammatory	☐ Penicillin	
☐ Latex		

*****Are you currently receiving IV bisphosphonates? No ☐ Yes ☐ If so, for how long_____**
Are you currently taking oral bisphosphonates (eg Fosamax)? No ☐ Yes ☐ If so, for how long _____

*****Pharmacy Name & Number:*** _____

Please list all: PRESCRIPTION MEDICATIONS, HERBAL MEDICATIONS & VITAMINS or SUPPLEMENTS that you are currently taking.	
1)	6)
2)	7)
3)	8)
4)	9)
5)	10)

Patient Name _____ Signature _____ Date _____