Patient History

Patient Name____
Social Security Number__________________________ Date of Birth____________
Address ____
City ____________________ State ________________ Zip__________
Home number _____________________________
Work number _____________________________
Mobile number ____________________________
Employer ____
Who Referred You to Our Office? ____
Physician ________________________________ Location __________________________
Phone Number _____________________________
Emergency Contact ________________________________ Phone Number ______________

1. Are you under any medical treatment now? ____Y ___ N
   If so, what type?
   ____
2. Have you had any serious illness, operation, or been hospitalized in the past 5 years?
   _____Y _____N
   If yes, what was the illness or problem?
   ____
3. Have you ever had orthodontic (braces) treatment? _____Y _____N
4. Have you ever had any periodontal (gum) treatment? _____Y ____N
5. Do your gums bleed when you brush? _______Y _____N
6. Do you wear removable dental appliances? ______Y _____N
7. Are you taking or have recently taken any medicine(s) including non-prescription medicine?
   _____Y _____N
   If yes, what medicine(s) are you taking?
   Prescribed: ____
   Over the Counter: ____
   Vitamins, natural or herbal preparations and/or diet supplements: __________________
8. Has a physician or previous dentist recommended that you take antibiotics prior to dental treatment?
   _____Y _____N If yes, what antibiotic and dose? _______________________________
9. Have you ever had an orthopedic total joint (hip, knee, elbow, finger) replacement? _____Y _____N
10. Are you using birth control products? ______Y _____N
11. Are you pregnant or nursing? ______Y _____N
12. Do you have jaw joint problems such as clicking, locking, or pain? _____Y _____N
13. Do you habitually clench or grind your teeth during the night or day? _______Y ______N
14. Do you have a history of drug abuse? ______Y _____N
15. Do you have a history of alcohol abuse? ______Y _____N

16. Are you a Tarheel fan? _____Y _____N

17. Have you ever required a blood transfusion? _______Y ______N

18. Have you ever taken blood thinners? _______Y ______N

19. Are you generally in good health at this time? ______Y _____N

20. Do you smoke? _____Y _____N If yes, how much daily? ______________________________

21. Do you use smokeless tobacco? _____Y _____N If yes, how much daily? ________________

22. Do you take daily aspirin? _____Y _____N If yes, how much daily? ________________________
Is this doctor recommended? _______Y _____N

23. Are you allergic to or have you ever reacted adversely to any of the following:

__Y __N Penicillin or other antibiotics
__Y __N Codeine
__Y __N Jewelry
__Y __N Iodine
__Y __N Sleeping Pills/Sedatives
__Y __N Sulfa Drugs
__Y __N Aspirin
__Y __N Latex
__Y __N Metals
__Y __N Dental Anesthetics

Other: ____

24. Please respond if you have or had any of the following diseases or problems:

__Y __N Abnormal Bleeding
__Y __N Anemia
__Y __N Blood Disorders
__Y __N Cardiovascular Disease
__Y __N Epilepsy
__Y __N Emotional Problems
__Y __N Pacemaker
__Y __N Heart Disease
__Y __N Tuberculosis
__Y __N Ulcers
__Y __N Kidney Disease
__Y __N Dry Mouth
__Y __N Osteoporosis
__Y __N Cancer/Chemotherapy/Radiation Treatment
__Y __N Hepatitis/Jaundice/Liver Disease
__Y __N Sexually Transmitted Disease
__Y __N Neurological Disorders
__Y __N Aids or HIV Infection
__Y __N Asthma
__Y __N Stroke
__Y __N Diabetes
__Y __N Glaucoma
__Y __N High Blood Pressure
__Y __N Fainting Spells or Seizures
__Y __N Heart Murmur
__Y __N Sinus Problems
__Y __N Rheumatic Fever
__Y __N Sleep Disorder
__Y __N Reflux
__Y __N Gastrointestinal Disease

25. Are there any other medical or dental conditions you feel the dentist should know before undertaking any dental treatments?

____

I certify that I have read and understand all of the above. I also acknowledge that my questions, if any, have been answered to my satisfaction. I will not hold my dentist, or any other member of this staff responsible for any error or omissions that I have made in the completion of this form.

Patient/Guardian Signature ____
Date ____________________________

Dental Insurance Information Form

Patient Name: ______________________ Social Security Number: ____________

Primary Insurance

Policy Holder Name: ____________________

Address (if different from patient): ______________________________

Relationship to patient: __________________

Social Security Number: __________________ Date of birth: ______________

Employer Name: ______________________

Insurance Company Name: ____________________ Group Number: ___________

Insurance Company Address: ______________________________

Insurance Company Phone Number: _____________ Member ID: ______________

Secondary Insurance

Policy Holder Name: ____________________

Address (if different from patient): ______________________________

Relationship to patient: __________________

Social Security Number: __________________ Date of birth: ______________

Employer Name: ______________________

Insurance Company Name: ____________________ Group Number: ___________

Insurance Company Address: ______________________________

Insurance Company Phone Number: _____________ Member ID: ______________

I hereby authorize Dr. Gerard R. Nazziola or anyone on his behalf to furnish all information to the insurance companies that may be required for them to process claims which are filed on my behalf. This authorization shall remain in effect until terminated or revoked by me. I may be entitiled to dental insurance benefits; I understand and agree that I am personally responsible for payment for all dental services rendered to me.

Signature: ______________________________

Dr. Jerry Nazziola – Periodontics & Implants Office Policies

Office Hours

Tuesday – Thursday 8:00AM – 5:00 PM Lunch 1:00-2:00

Financial Information

In compliance with the Truth in Lending Law, here is our credit policy:

It is customary to take care of your fees at the time service is rendered.

To assist our patients with this policy we accept checks, cash, Visa, MasterCard, and Discover. If you have dental insurance, we will be happy to file your insurance claim for you on the day of service.

All insurance amounts that are quoted by our office are ESTIMATES ONLY based on the patient's membership in a valid insurance group and the information we have on that plan. Even though we accept the assignment of YOUR insurance benefits to lessen the financial impact of your dental care, these benefits are actually yours. Therefore, you must petition the insurance carrier. It has been our experience that third party involvement (our office) is not as effective as you contacting the insurance carrier either directly or through your employer.

It should be further understood that there must be at least a 24 hour notification for canceling an appointment or a service charge may be implemented on any treatment greater than 30 minutes.

Current Patient Medication Information:

You will be asked to provide us with a current list of medications (based on your medical history). If asked to do so, please list the name of the medication, the dose, strength, and how you are instructed to take it. We would ask also that you provide us with the physician's name who prescribed the medication.

Pharmacy Information

Please identify the pharmacy you prefer to use in the event we would need to prescribe any medications relating to your specific dental treatment.

Pharmacy:______________________________
Location:______________________________
Phone:________________________________

Patient Signature:__________________________________
Date:________________________________