Four Rivers Periodontics
& Implant Specialists

PATIENT HEALTH HISTORY

Name: First, Middle, Last | Preferred Name | Sex | Birth Date | Marital Status

Address (Street, City, State, Zip Code)

Home Phone | Office Phone | Business Name and Address

Dentist's Name | Referred to This Office By | Occupation/Employer

Person Responsible for Payment of Account | Relation | Phone

Responsible Party's Address

Person to Notify in Case of Emergency

DENTAL INSURANCE INFORMATION

Insurance Holder Information

Insurance Holder's Name | Birth Date | Social Security Number

Insurance Holder's Employer | Employer's Address

Primary Insurance Company

Name & Address

Subscriber's Name | Group, Company, or Employer's Name

Group Number | Patient Relationship to Subscriber (self, spouse, child, etc.)

Secondary Insurance Company

Name & Address

Subscriber's Name | Group or Company Name

Group Number | Patient Relationship to Subscriber (self, spouse, child, etc.)

MEDICAL HISTORY

Medical Doctor's Name _____ Address _____ Phone _____

Date of My Last Physical Examination _____ Results _____

Are you being treated by a medical doctor now? If yes, for what reason?

Are you taking any medication at the present time? If yes, please list?

Are you sensitive or allergic to any medicine? If yes, what?

Have you ever been hospitalized or had any surgical operations? If yes, list reasons and dates.

Have you ever had any blood transfusions? If yes, give reason.

Have you had or are you:

□ Yes	□No	Heart Disease	□ Yes	□No	COPD, emphysema, or other Lung Disease
□ Yes	□No	High Blood Pressure			
□ Yes	□No	Low Blood Pressure	□ Yes	□No	Asthma
□ Yes	□No	Heart Murmur	□ Yes	□No	**Bisphosphonate Medication**
□ Yes	□No	Heart Attack	□ Yes	□No	Tuberculosis
□ Yes	□No	Angina Pectoris/Chest Pain	□ Yes	□No	Allergies or Hives
□ Yes	□No	Pacemaker	□ Yes	□No	Sinus Issues
□ Yes	□No	Rheumatic Fever	□ Yes	□No	Hay Fever
□ Yes	□No	Diabetes	□ Yes	□No	Stroke
		Latest HbA1c & date: _____			
□ Yes	□No	Metabolic Syndrome	□ Yes	□No	Epilepsy or Seizures
□ Yes	□No	Obesity	□ Yes	□No	Cognitive Impairment
□ Yes	□No	Hypoglycemia	□ Yes	□No	Psychiatric Treatment
□ Yes	□No	Ulcers (Stomach or Intestinal)	□ Yes	□No	Alzheimer's Disease
□ Yes	□No	Kidney Disease	□ Yes	□No	Cancer
□ Yes	□No	Kidney Dialysis	□ Yes	□No	Chemotherapy (Cancer, Leukemia)
□ Yes	□No	Bladder Disease	□ Yes	□No	X-Ray or Radiation Treatment
□ Yes	□No	Liver Disease	□ Yes	□No	Problems in Healing
□ Yes	□No	Hepatitis	□ Yes	□No	Arthritis
□ Yes	□No	Anemia	□ Yes	□No	Fainting or Dizzy Spells
□ Yes	□No	AIDS/HIV Positive	□ Yes	□No	Acid Reflux
□ Yes	□No	Osteoporosis or Osteopenia	□ Yes	□No	Dry Mouth
□ Yes	□No	Cold Sores/Fever Blisters	□ Yes	□No	Glaucoma
□ Yes	□No	Drug Addiction	□ Yes	□No	Blood Diseases
□ Yes	□No	Joint Replacement	□ Yes	□No	Leukemia
□ Yes	□No	Organ Transplant	□ Yes	□No	Hemophilia
□ Yes	□No	Thyroid Disease (or Goiter)	□ Yes	□No	Sleep Apnea

Do you have any health conditions not listed above? Please explain: _____

□ Yes □No Do you have pain in the chest upon exertion?
□ Yes □No Do you have shortness of breath after mild exercise?
□ Yes □No Do you use extra pillows to sleep?
□ Yes □No Do your ankles swell?
□ Yes □No Do you bruise easily?
□ Yes □No Does your mouth frequently become dry?
□ Yes □No Are you following a diet?
□ Yes □No Do you have difficulty swallowing?
□ Yes □No Has a doctor ever said you have cancer or a tumor?
□ Yes □No Have you ever had excessive bleeding from a cut or wound?
□ Yes □No Do you have frequent severe headaches?
□ Yes □No Do you sometimes take medicine to relieve anxiety?

Sleep

□ Yes □No Do you snore?
□ Yes □No You, or your spouse, would you consider your snoring louder than a person talking?
□ Yes □No Your snoring occurs almost every night?
□ Yes □No Your snoring is bothersome to your bed partner?
□ Yes □No Do you feel that in some way your sleep is not refreshing or restful?
□ Yes □No Do you wake up at night or in the morning with headaches?
□ Yes □No Do you experience fatigue during the day and have difficulty staying awake?
□ Yes □No Do you have trouble remembering things or paying attention during the day?
□ Yes □No Do you have high blood pressure?

Females

□ Yes □No Did you have any complications during pregnancy (if you have never been pregnant, answer no)
□ Yes □No Are you pregnant? (date of delivery _____)
□ Yes □No Are you taking oral contraceptives (birth control pills)?

Social History

□ Yes □No Do you, or have you previously used tobacco products or smoke any products?
If yes, what type(s)? _____

If yes, how much? _____

If yes, how long have you used these products? _____

□ Yes □No Do you drink alcohol?
If yes, how much do you drink in a typical day, week, or month?

□ Yes □No Do you use recreational drugs or marijuana?
If yes, what type? _____ If yes, how often? _____

Please explain all yes answers from above (the past 2 pages):

_____

_____

_____

_____

_____

_____

DENTAL HISTORY

□ Yes □No Have you had any serious trouble associated with any previous dental treatment?
If yes, explain: _____
□ Yes □No Do you bleed excessively after tooth extraction?
□ Yes □No Have you recently had dental x-rays? If yes, when:_____
□ Yes □No Have you had undesirable reactions to local or general anesthetics (e.g., Novocain or gas)?
□ Yes □No Do you clench or grind your teeth?
□ Yes □No Are any of your teeth sensitive to cold or sweets?
□ Yes □No Are you dissatisfied with the appearance or function of your teeth?
□ Yes □No Have you had excessive swelling or pain after oral surgery?
□ Yes □No Have your teeth been cleaned recently? If yes, when:_____
□ Yes □No Do you have bleeding gums?
□ Yes □No Do you have a bad taste in your mouth?
□ Yes □No Does food pack between your teeth?
□ Yes □No Does your jaw click or pop when you chew?
□ Yes □No Have you ever received treatment for periodontal disease?
□ Yes □No Has a dentist ever ground your teeth to correct your bite?
□ Yes □No Are any of your teeth loose, or are you concerned about any teeth loosening?
□ Yes □No Do you currently have any dental implants, dentures, or partials? If yes, which:_____
□ Yes □No Are you willing to become actively involved in the treatment of your periodontal disease?
□ Yes □No Are you anxious about dental care? If yes, please rate on a scale of 1-10:_____

How important are your teeth and oral health to you? Please rate on a scale of 1-10:_____

How frequently do you brush your teeth?
□ 3 (+) a day □ Twice a day □ Once a day □ Weekly □ Seldom

How frequently do you floss your teeth?
□ 1 (+) a day □ 2 – 6 weekly □ 1-6 monthly □ Seldom □ Never

If you could change anything about your mouth, teeth, or smile, what would it be? _____

_____

What is your chief complaint concerning your mouth or teeth? _____

_____

Preferred Pharmacy Information

_____ _____
Pharmacy Phone Number

_____
Address

To the best of my knowledge, all of the above answers are true and correct. If I have any change in my health, I will inform Dr. Scully and her staff at my next appointment. By signing, I also consent to a consultation with Dr. Scully to determine a personalized treatment plan to help reach my goals regarding my oral health.

_____ _____
Signature of Patient Date

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FINANCIAL POLICY STATEMENT

Payments for services, including deductibles and copayments, are due at the time of the service unless other arrangements have been made prior to treatment. Payments may be made using cash, check, debit card, or credit card (Mastercard or Visa). Any arrangements for third-party financing must be made before starting treatment.

Four Rivers Periodontics and Implant Specialists is not contracted with any specific dental benefit plans. We are happy to help submit the claims necessary as a courtesy to you. The dental benefit contract is an agreement between you, your employer, and the dental benefit company, and we are not a party to that contract. You are ultimately responsible for all charges. We cannot guarantee that any coverage estimated by your plan will be paid once a claim is filed.

In order to maximize your benefits and because plans differ from carrier to carrier, and from policy to policy, our office may refer you to your carrier or your employer's benefits coordinator for assistance in understanding your plan. Please note that your dental plan is intended to cover some but not all dental care costs, and not all services are covered by dental plans. Covered services are determined by your company and do not give any indication of treatment you may actually need. You are responsible for payment of all services regardless of the payable benefit. Prior to completion of treatment, all discussion of fees are estimates, and are subject to change. Reduction or rejection of your claim by your insurance company does not relieve you of your financial obligation.

Checks that are returned to our office from your financial institution are subject to a $25 returned check fee. This fee covers the processing fees that are charged to our office. We would be happy to discuss our charges and how they relate to your particular situation.

If your account becomes past due, we will take necessary steps to collect this debt and a fee of $75 may be applied to your account for each late payment. If we have to refer your account to a collection agency, you agree to pay all of the collection fees that are incurred.

A minimum of 48 hours notice is required for rescheduling appointments. We reserve time just for you, please be considerate of our time as well. If appropriate notice is not given, a fee may be charged.

Please answer the following question and indicate your understanding and acceptance of these financial policies by signing below.

Are you in bankruptcy or have you been in the past 10 years? Yes No

Are you interested in learning about financing options for treatment? Yes No

Patient's name (print) : _____ Date: _____

Patient, guardian, or guarantor signature _____ Date: _____

Witness _____ Date: _____

Four Rivers Periodontics
& Implant Specialists

AUTHORIZATION FOR USE AND RELEASE OF PERIODONTAL INFORMATION FOR RESEARCH, EDUCATION, AND PROMOTIONAL PURPOSES

Four Rivers Periodontics and Implant Specialists
1351 Jefferson St, Suite 202
Washington, MO 63090

Patient's name: _____

Date of birth: _____

I authorize the use and disclosure of any or all of my periodontal records, including but not limited to photos, records, slides, x-rays, and other viewings of my care and treatment before and after completion of procedures for research, education, and promotional purposes. Identifying information will be removed whenever possible.

1. I understand that I may revoke this authorization at any time, but revocation will not apply to information that has already been released. Revocations should be sent to the periodontist at the address as noted on top of this form.
2. I understand that I may refuse to sign this authorization and that the periodontist may not condition my treatment on whether I provide this authorization.
3. I understand that no recipient of my periodontal information is covered by the federal privacy regulations that protect the privacy of healthcare information, and that after its release, my information will be subject only to the recipient's privacy policies and not to federal law.
4. I understand that I may receive a copy of this authorization by submitting a request to the periodontist at the address noted on the top of this form.

_____ _____
Signature of Patient or Authorized Person Date

_____
Relationship to Patient/Reason Patient is Unable to Sign

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CONSENT TO ELECTRONIC COMMUNICATIONS AND SHARED INFORMATION (HIPAA)

Patient Name: _____ Date of Birth:_____

I agree that the dental practice may communicate with me electronically at the email address below, and/or via text message at the phone number below.

I am aware that there is some level of risk that third parties might be able to read unencrypted emails.

I am responsible for providing the dental practice any updates to my email address and cell phone number.

I can withdraw my consent to electronic communications by calling (636) 283-2288.

I have been given the opportunity to review the Notice of Privacy Practices.

Email Address (PLEASE PRINT CLEARLY):

_____

Cell Phone Number:

_____

I authorize messages to be left at the following phone numbers:

Home: _____

Cell: _____

Work: _____

Other: _____

I authorize Four Rivers Periodontics and Implant Specialists to share my health information with the following people:

Name: _____ Relation: _____ Phone Number: _____

Name: _____ Relation: _____ Phone Number: _____

Name: _____ Relation: _____ Phone Number: _____

In addition, Four Rivers Periodontics and Implant Specialists shares information with other dentists and physicians as needed for treatment. Please let us know if you do not want information shared with a particular health care provider.

Patient Signature:_____ Date:_____