Practice Limited to Periodontics and Dental Implant Surgery

David A Campbell, DMD, MS **Alex F Podaru, DMD, MS**

Health History

Please fill in the following information. Your answers are for our records only and will be kept strictly confidential subject to applicable laws. Please note that you will be asked some questions concerning your health. This information is vital to allow us to provide you the best care possible.

First Name: _____ Middle Name: _____ Last Name: _____

Date of Birth: _____ Email Address: _____

Contact Information

Home #: _____

Work #: _____

Mobile #: _____

Patient Mailing Address: _____

Patient Billing Address: _____

Emergency Information

Emergency Contact: _____ Emergency #: _____

Family Doctor: _____ Family Doctor #: _____

☐ Has the main contact for the family, (usually a parent or guardian) changed since your last visit?

☐ Has the main person responsible for payments for the family, (usually a parent or guardian) changed since your last visit?

Other Information

Social Security Number: _____ Occupation: _____

☐ Has your insurance information changed since your last visit? _____

Dental Information

☐ Do your gums bleed when you brush or floss?

☐ Are your teeth sensitive to cold, hot, sweets, or pressure?

☐ Does food or floss catch between your teeth?

☐ Have you had any periodontal (gum) treatment?

☐ Have you ever had orthodontic (braces) treatment?

☐ Have you had any problems associated with previous dental treatment?

☐ Is your home water supply fluoridated?

☐ Do you drink bottled or filtered water?

☐ Are you currently experiencing dental pain or discomfort?

☐ Do you have earaches or neck pains?

☐ Do you have any clicking, popping or discomfort in your jaw?

☐ Do you grind your teeth?

☐ Do you have any sores or ulcers in your mouth?

☐ Do you wear partial dentures?

☐ Do you wear full dentures?

☐ Have you ever had a serious injury to your head, neck or mouth?

Medical Information

Allergies (Please mark all that apply)

☐ Acetaminophen/Tylenol® ☐ Acrylic ☐ Animals ☐ Aspirin

☐ Codeine ☐ Demerol ☐ Erythromycin ☐ Fluoride

☐ Food ☐ Hay fever/seasonal ☐ Ibuprofen/Motrin®/Advil® ☐ Iodine

☐ Latex ☐ Local anesthetic ☐ Metals ☐ Morphine

☐ Penicillin ☐ Sulfa ☐ Tetracycline ☐ Other: _____

Conditions (Please mark all that apply)

- Abnormal/excessive bleeding
- AIDS or HIV infection
- Alzheimer's/dementia
- Anemia
- Angina
- Anxiety
- Arteriosclerosis
- Arthritis
- Asthma
- Autoimmune disease
- Back problems
- Congestive heart failure
- Damaged heart valves
- Diabetes
- Eating disorder
- Emphysema
- Epilepsy
- Fainting spells or seizures
- Frequent headaches
- Gastrointestinal disease
- G.E. Reflux/persistent heartburn
- Glaucoma
- Gout
- Hearing difficulties
- Heart attack
- Heart murmur
- Heart rhythm disorder
- Hemophilia
- Hepatitis
- Hepatitis, jaundice or liver disease
- High blood pressure
- Joint Replacement
- Kidney Disease
- Kidney problems
- Low blood pressure
- Low pain tolerance
- Malnutrition
- Blood disease
- Blood Thinners
- Blood transfusion
- Breathing problems/ respiratory disease
- Bronchitis
- Cancer/chemotherapy/ radiation treatment
- Cardiovascular disease
- Chest pain upon exertion
- Chronic pain
- Mechanical/Animal Heart Valve (Pre-Med)
- Mitral valve prolapse
- Neurological disorders
- Night sweats
- OSTEOPOROSIS MEDICATIONS/INJECTIONS
- Osteoporosis/Paget's disease
- Other congenital heart defects
- Pacemaker
- Persistent swollen glands in neck
- Physical Challenges
- Pregnant
- Pre-Medication
- Psychiatric care
- Recurrent Infections
- Rheumatic fever
- Rheumatic heart disease
- Rheumatoid arthritis
- Severe headaches/migraines
- Severe or rapid weight loss
- Sexually transmitted infection (STI)
- Sinus trouble
- Stroke
- Systemic lupus erythematosus
- Thyroid problems
- TMJ

- TMJ Disorder
- Tuberculosis
- Tumors or growths
- Ulcers
- Wheelchair Access
- Other: _____

Preferred Pharmacy: _____

Pharmacy #: _____

Date of Last Physical Exam: _____

Please mark all that apply.

- Do you have severe issues with coughing?
- Have you ever reacted adversely to any medications or injections?
- Do you drink alcoholic beverages?
- Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?
- Has there been any change to your general health within the past year?
- Do you use tobacco (smoking, snuff, chew, bidis)?
- Have you had a serious illness, operation or been hospitalized in the past 5 years?
- Are you wearing a nicotine patch?
- Are you taking any prescription or over-the-counter medicines?
- Do you have sleep apnea?
- Are you pregnant?
- Are you taking birth control or hormone replacement?
- Have you ever taken FosaMax®, Boniva®, Actonel®, Lopria or other medications containing bisphosphonates?
- Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?
- Please list any surgical procedures you have undergone and when they occurred.

  _____
  _____
  _____

Please read the above, and understand that the information provided in this form is accurate. A truthful health history will help ensure the best possible dental treatment. The information provided here will be used by the doctor and patient to inform any further discussion of the patient's health prior to or during an appointment. By signing below, you also acknowledge that you will not hold the dentist, the dental practice or any other member of the practice staff responsible for any action or lack of action because of errors or omissions that may have been made during the completion of this form.

X_____

Cancellation Policy

We understand that unplanned issues can come up and you may need to cancel an appointment. If that happens, we respectfully ask for scheduled appointments to be cancelled at least 48 hours in advance. Our doctors & hygienists want to be available for your needs and the needs of all our patients. When a patient does not show up for a scheduled appointment, another patient loses an opportunity to be seen. Although we have always had a cancellation policy, circumstances have caused us to enforce a policy of charging for no-show appointments, and those appointments not cancelled within 48 hours. There may be a fee assessed if we do not receive a call to cancel an appointment. Thank you for being a valued patient and for your understanding and cooperation. This policy will enable us to open otherwise unused appointments to better serve the needs of all patients.

X_____

Consent for Services and Financials

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed unless other arrangements are made. Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any collections to the patients account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. A service charge of 1 ½ % per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied. I understand that any fee estimate for this dental care can only be extended for a period of twelve months from the date of patient examination. In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for the services shall be billed unless objected to, by me in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any future term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant permission to you or your assignee to telephone me to discuss this statement or my treatment.

X_____

HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization. I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality. I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED.

Please list any other parties who can have access to your health information (This includes any friend, family member, or caregiver who can have access to this patient's records):

Patient First Name: _____ Patient Last Name: _____

Legal Representative: _____Description of Authority: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

X_____

Consent for Text Communications

I grant permission to the dental practice to communicate with me electronically at the email address and/or mobile phone number I have provided. I am aware that there is some level of risk that third parties might be able to read unencrypted emails. I further agree that I am responsible for providing the dental practice any updates to my email address and/or mobile phone number. I understand by consenting to text communications, I will receive appointment reminders and confirmations, billing statements, etc. I can opt-out at anytime by calling Lakeland Periodontics at (863)687- 9227

X_____

Consent for Internet Communications

I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me: and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice website with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will at all times during the terms of this agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATINT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR SERVICES.

X_____