Patient Information

Patient's Name ______________________________Marital Status ______________ Date of Birth ______/______/_______

Address ____ City ___________________________ Zip ______________

Home Ph # (907)___________________ Cell Ph # (907) ___________________ Work Ph # (907) ___________________

Parent's Name ____

Employer ____ City ____________________________________

Referring Dentist ___________________________________ Physician ____

Spouse's Name _____________________________ Date of Birth _____/_____/_____ Employer ______________________

Dental Insurance

Primary Ins. Co. ______________________________ Group # ___________________ ID #________________________

Insured Name _________________________S.S. # _______-_______-_______ Insured Date of Birth _____/______/______

Secondary Ins. Co. ____________________________ Group # _________________ ID #________________________

Insured Name _________________________S.S. # _______-_______-_______ Insured Date of Birth _____/______/______

Contact Preferences

How would you like us to contact you? (appt. reminder, questions, etc.) Home ____ Cell ____ E-mail ____ No preference _____

If you prefer e-mail, what is your e-mail address? ____

If you have a balance due on your treatment, would you prefer we send you a statement via regular mail or by e-mail?

Regular mail _____ E-mail ______ Either is fine _____

In case of an emergency, contact:

Name ______________________________Relationship _____________________Phone # _______________________

Patient Name:

Medical History

Health Information	Yes	No	?
1. Has there been any change in your general health during the last year?			
2. Are you receiving any treatment by any doctor now?			
3. Are you taking any medicines now? Please indicate below under "Additional Information":			
4. Have you ever had an operation? If so, when?			
5. Have you ever had a serious illness?			
6. Has a dentist or physician ever told you that you had a tumor or cancer?			
7. Have you ever had rheumatic fever?			
8. Have you ever had excessive bleeding following the extraction of teeth or from a cut?			
9. Are you sensitive to any particular medicine (aspirin, penicillin, etc.)?			
10. Do you suffer from frequent severe headaches?			
11. Have you had a recent change in your appetite, bowel habits or sleep pattern?			
12. Do you have any artificial heart valves or joints?			
13. Do you require antibiotics prior to any dental treatment?			
14. Has a physician ever said you had heart trouble?			
15. Have you ever had rheumatic heart disease?			
16. Has a physician ever said your blood pressure was too high or too low?			
17. Has a physician ever told you that you had ulcers?			
18. Have you ever been jaundiced (Hepatitis)?			
19. Do you have asthma?			
20. Have you ever had tuberculosis or HIV?			
21. Have you ever had any form of venereal disease (syphilis, gonorrhea, herpes)?			
22. Have you ever had diabetes?			
23. Have you ever had a nervous breakdown?			
24. Has a physician ever told you that you had epilepsy?			
25. Do you consider yourself a nervous person?			
26. Do you have arthritis or rheumatism?			
27. Have you ever had gum treatments?			
28. Do you think your teeth are moving or drifting?			
29. Do you grind or clench your teeth when you are nervous or while sleeping?			
30. Do you smoke?			

Female Patients Only	Yes	No	?
31. Are you pregnant?			
32. Do you take any medication for Osteoporosis?			

Additional Information

PARENT'S SIGNATURE ______________________ DATE ______________

CONSENT TO PERIODONTAL TREATMENT

I understand that I will be receiving recommendations for appropriate periodontal treatment. If I have any questions about any recommended treatment, I can ask for an explanation at any time. This is my consent to the treatment deemed or advisable and to the use of local anesthesia.

I understand that occasionally there are complications of the surgery, drugs, and anesthesia. The more common complications are pain, infection, swelling, bleeding, bruising and discoloration, temporary or permanent numbness and tingling of the lip, tongue, chin, gums, cheek, or teeth. More rarely, but occasionally occurring, are changes in the occlusion; temporomandibular joint discomfort; injury to adjacent teeth or other tissues; referred pain in the ear, neck or head; vomiting, allergic reactions; bone fractures and delayed healing. Sinus complications, which may include a nasal antral fistula or opening into the sinus from the mouth, may rarely occur.

Medications, drugs, anesthetics, and prescriptions may cause drowsiness and lack of awareness and coordination which could be increased by the use of alcohol or other drugs; thus, I have been advised not to operate any vehicle or hazardous devices or work while taking such medications and/or drugs or until fully recovered from the effects of the above.

I understand that there is no warranty or guarantee as to any result and/or cure.

_____________________________________ _______________

Signature of Patient, Parent or Guardian Date

CONSENT TO USE OR DISCLOSE DENTAL AND MEDICAL INFORMATION

I authorize Dr. Jeffrey D. Rogers, DDS to use and disclose the dental, medical and health information

of ____ for the following purpose(s).
(patient name)

- **Treatment** – includes activities performed by a dentist or dental hygienist, as well as coordinating or managing care provided to you with third parties, and consultations involving dentists, physicians, and other health care providers.

- **Payment** – includes activities involved in determining whether you are eligible for dental plan coverage, billing matters, and reimbursement for your dental benefit claims, as well as utilization management programs addressing review of dental services for clinical necessity, appropriateness of charges, precertification and preauthorization of services.

- **Health Care Operations** – includes associated business and administrative affairs of this office.

You have the right to revoke this Consent. However, you must revoke this Consent in writing. Any revocation would not pertain to information already used or disclosed pursuant to his Consent during the time frame within this Consent is effective.

_____________________________________ _______________

Signature of Patient, Parent or Guardian Date