Welcome to Austin Periodontal Associates - Dr. Andrew D. Verrett

PATIENT INFORMATION			INSURANCE AND POLICY HOLDER INFORMATION		
FIRST NAME	LAST NAME/MIDDLE INITIAL		FIRST NAME	LAST NAME/MIDDLE INITIAL	
DATE OF BIRTH:	☐ FEMALE ☐ MALE	SS#	**DATE OF BIRTH:**	☐ FEMALE ☐ MALE	SS# OR ID#
ADDRESS			ADDRESS		
CITY STATE ZIP			CITY STATE ZIP		
HOME NUMBER	CELL NUMBER		HOME NUMBER	CELL NUMBER	
WORK NUMBER	EMPLOYER		EMPLOYER	WORK NUMBER	
EMAIL ADDRESS			EMAIL ADDRESS		
RESPONSIBLE PARTY:			DENTAL INSURANCE		
RELATIONSHIP TO PATIENT:			DENTAL INSURANCE PHONE NUMBER		
EMERGENCY CONTACT INFORMATION					

PREVIOUS OR CURRENT DENTAL TREATMENT

REFERRING DENTIST	PHONE NUMBER
HOW LONG AS A PATIENT?	
LAST DENTAL CLEANING OR SCALING?	
HOW CAN WE HELP YOU?	
DENTAL EXPERIENCES – POSITIVE OR NEGATIVE? POSITIVE	
BLEEDING GUMS WHEN BRUSH / FLOSS? NO	
TMJ DISCOMFORT / CLICKING NOISE? NO	
TEETH GRINDING / SNORING / SLEEP APNEA? NO	
DO YOU LIKE HOW YOUR TEETH LOOK? YES	
CURRENTLY WEARING BRACES, PARTIALS, OR DENTURES? NO	
SENSITIVE TEETH TO COLD, HEAT, SWEETS? NO	
DISCOMFORT/PAIN? NO	
EVER BEEN DIAGNOSED WITH GUM DISEASE? NO	
RELATIVE DIAGNOSED WITH GUM DISEASE? NO	
EVER HAD DENTAL SURGERY? NO COMPLICATIONS? NO	
WHAT DENTAL AIDS DO YOU USE:	

HAVE YOU OR ARE YOU TAKING ANY OF THE FOLLOWING MEDICATIONS?

A. ANTICOAGULANTS, BLOOD THINNERS OR ASPIRIN YES NO
B. TRANQUILZERS OR ANTIDEPRESSANTS YES NO
C. NITROGLYCERIN, STEROIDS, OR HORMONES YES NO
D. OSTEOPOROSIS THERAPY OR IV INFUSIONS YES NO

PLEASE LIST ALL CURRENT MEDICATIONS:

(For Dr. or Nurse to Complete)

BP_____P_____HEIGHT_____WEIGHT_____

NOTES:

PREVIOUS OR CURRENT MEDICAL HISTORY

PHYSICIAN:		
PHONE NUMBER		
LAST PHYSICAL EXAM		
CURRENT THERAPY/HISTORY OF MAJOR SURGERY:		
	YES	NO
ALLERGIES, REACTIONS TO ANY MEDICATIONS? **IF YES, LIST**:	☐	☐
INJURY TO YOUR FACE OR JAWS?	☐	☐
NEED ANTIBIOTIC PREMEDICATION BEFORE DENTAL VISITS?	☐	☐
WHY? WHICH ANTIBIOTIC?	☐	☐
SINUS TROUBLE, ASTHMA, HAYFEVER?	☐	☐
DO YOU SMOKE OR USE SMOKELESS TOBACCO?	☐	☐
IF YES: WHICH? HOW OFTEN?	☐	☐
EYE PROBLEMS (CATARACTS OR GLAUCOMA)?	☐	☐
HIGH OR LOW BLOOD PRESSURE? (CIRCLE ONE OR BOTH)	☐	☐
EARACHES, RINGING IN EARS, HEARING LOSS?	☐	☐
CANCER, TUMOR, RADIATION OR CHEMOTHERAPY?	☐	☐
FREQUENT NECK PAIN OR HEADACHES?	☐	☐
FAMILY HISTORY OF DIABETES?	☐	☐
DO YOU HAVE DIABETES? CONTROLLED OR UNCONTROLLED? IF YES, CONTROLLED BY: INSULIN DIET MEDICATION BLOOD SUGAR:	☐	☐
LUNG PROBLEMS (TUBERCULOSIS, BRONCHITIS)?	☐	☐
LIVER CONDITION (HEPATITIS, CIRRHOSIS)?	☐	☐
STOMACH PROBLEMS (ULCER, GASTRITIS, COLITIS)?	☐	☐
THYROID, KIDNEY OR BLADDER TROUBLE?	☐	☐
ARTIFICIAL JOINTS, RHEUMATIC FEVER?	☐	☐
JOINT REPLACMENT? DATE?	☐	☐
HEART ATTACK, CHEST PAINS, PACEMAKER, MURMUR?	☐	☐
HEART SURGERY, HEART DISEASE, PALPITATIONS?	☐	☐
BLOOD DISORDER (ANEMIA, LEUKEMIA, BLEEDING, HEMOPHILIA, HIV, BLOOD TRANSFUSIONS, AIDS, DIALYSIS)?	☐	☐
APHTHOUS ULCERS, CANKER OR COLD SORES?	☐	☐
EPILEPSY OR SEIZURES? RECENT WEIGHTLOSS OF GAIN?	☐	☐
OSTEOPOROSIS? ANY THERAPY FOR OSTEOPOROSIS: IV OR PILL?	☐	☐
ARE YOU PREGNANT / NURSING / MENOPAUSAL?	☐	☐
ANY OTHER CONDITION NOT LISTED?	☐	☐

I have read and understand the above questions and to the best of my knowledge, all of preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist at the next appointment. This office may share medical/ dental information with other medical/ dental providers for my care. I authorize this office to affix my name to any documents related to health insurance benefits and to receive payment from my insurance company. I understand that I am financially responsible for all charges incurred for services provided in this office whether or not paid by my insurance. A finance charge will be incurred on all outstanding balances. I have received or have read a copy of this office's Notice of Privacy Practices. **Advance Beneficiary Notice of Non-coverage Medicare Benefits: I understand Austin Periodontal Associates are not providers of Medicare, therefore, I cannot file any claim with Medicare and I agree to pay 100% of all procedures with or without dental insurance.**

SIGNATURE:_____ **DATE:**_____

For office us only: We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:
____ _Individual refused _____ Communication barriers_____Emergency Other_____

FORM CLEAR