Practice Limited to Periodontics & Implant Surgery

PATIENT INFORMATION & INSURANCE

Please select one: ○ **Dr.** ○ **Mr.** ○ **Mrs.** ○ **Ms.** ○ **Miss**

First Name ______________________ **Last Name** ______________________

Prefers to be called: (e.g. "John" "Mr. Jones") ______________ ○ **Female** ○ **Male**

Date of Birth ______________________ **SSN** ______________________

Home Address ____

City ______________________ **State** ____________ **Zip** ____________

Home Phone (   ) ______________________ **Cell Phone (   )** ______________________

Email ______________________ **Business Phone (   )** ______________________

More convenient way(s) to contact you:

○ **Cell Phone** ○ **Email** ○ **Home Phone** ○ **Business Phone**

Employer ______________________ **Occupation** ______________________

Emergency Contact ______________________ **Emergency Contact Phone Number (   )** ______________

Pharmacy Name ______________________ **Pharmacy Phone Number (   )** ______________

Whom may we thank for referring you? ____

Is there someone else (e.g. parent for minor) who will be financially responsible for this account? If so, please list.

Name of Responsible Party ______________________ **Phone Number (   )** ______________________

Date of Birth ______________________ **SSN** ______________________

PRIMARY DENTAL INSURANCE *(if applicable)*

Name of Subscriber ______________________
FIRST NAME LAST NAME

○ **Female** ○ **Male**

Relation to Patient ______________________

Subscriber Date of Birth ______________________

Subscriber SSN ______________________

Subscriber Employer ______________________

Insurance Company ______________________

Address ______________________

City/State/Zip ______________________

Phone Number (   ) ______________________

Insurance ID ______________________

Group Number ______________________

SECONDARY DENTAL INSURANCE *(if applicable)*

Name of Subscriber ______________________
FIRST NAME LAST NAME

○ **Female** ○ **Male**

Relation to Patient ______________________

Subscriber Date of Birth ______________________

Subscriber SSN ______________________

Subscriber Employer ______________________

Insurance Company ______________________

Address ______________________

City/State/Zip ______________________

Phone Number (   ) ______________________

Insurance ID ______________________

Group Number ______________________

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Practice Limited to Periodontics & Implant Surgery

Black Beagle[SM]
DMD
DDS
MSD
dentistry meets aesthetics

PATIENT HEALTH QUESTIONNAIRE

Patient Name ______________________________

Family Dentist ______________________________

Frequency and type of dental care ______________________________

Have you had previous periodontal care? ○ Yes ○ No

If yes, when and by whom? ______________________________

Have you ever had orthodontic treatment? ○ Yes ○ No

Do you have or have you experienced any of the following?

- ○ abscesses
- ○ bad taste/breath
- ○ bleeding gums
- ○ discomfort
- ○ floss snagging
- ○ food impaction
- ○ recent tooth loss
- ○ sensitivity to biting pressure
- ○ loose teeth
- ○ spontaneous tooth movement

Do you use: ○ Gum ○ Coffee ○ Soft Drinks ○ Tea ○ Breath Mints

Is your toothbrush: ○ Hard ○ Medium ○ Soft

Does your M.D. require you to pre-medicate with antibiotics prior to all dental procedures? ○ Yes ○ No

If yes, why? ______________________________

Are you allergic to any medications or drugs? ○ Yes ○ No

If yes, please list. ______________________________

Have you ever had adverse reaction to any drugs, anesthetics, sedatives, narcotics, aspirin, ibuprofen (Motrin)? ○ Yes ○ No

If yes, please list. ______________________________

Have there been any changes in your general health in the past year? ○ Yes ○ No

Have you had a serious illness, operation or hospitalization within the past five years? ○ Yes ○ No

If yes, please describe ______________________________

Are you taking or have you recently taken prescribed medications, inhalers, over the counter natural or herbal preparations? ○ Yes ○ No

If yes, please list ______________________________

Have you ever taken or been treated with bisphosphonates (medications to treat bone loss) of any kind? ○ Yes ○ No

If yes, what and how long? ______________________________

Have you ever had excessive bleeding that required special treatment? ○ Yes ○ No

Is there a history of Diabetes in your family? ○ Yes ○ No

Do you use any kind of tobacco? ○ Yes ○ No

If yes, how much: per day, week, month ______________________________

Do you use any kind of alcohol? ○ Yes ○ No

If yes, how much: per day, week, month ______________________________

Do you have any history of substance abuse or do you currently use recreational drugs? ○ Yes ○ No

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Black Beagle DMD DDS MSD

dentistry meets aesthetics

Patient Name ____________________

Choose all of the following that you may have had in the past or that currently apply to you:

CARDIOVASCULAR

- ○ chest pain upon exertion
- ○ shortness of breath
- ○ high blood pressure
- ○ low blood pressure
- ○ heart valve prolapse
- ○ congenital heart lesion
- ○ rheumatic fever
- ○ heart murmur
- ○ damaged heart valve
- ○ heart arrhythmia
- ○ tachycardia
- ○ heart surgery
- ○ heart pacemaker
- ○ blood thinner

NEUROLOGIC/PSYCH

- ○ seizures/epilepsy
- ○ stroke
- ○ migraines
- ○ depression/anxiety
- ○ mental health problems

EYE

- ○ cataracts
- ○ glaucoma
- ○ wear contact lenses
- ○ severely impaired vision

KIDNEY

- ○ kidney disease
- ○ impaired kidney function
- ○ hemodialysis

PULMONARY

- ○ asthma
- ○ emphysema
- ○ tuberculosis

GENERAL

- ○ AIDS/HIV+
- ○ alcoholism
- ○ anorexia or bulimia
- ○ ARC
- ○ arthritis
- ○ blood transfusions
- ○ cancer
- ○ chemotherapy
- ○ chronic fatigue
- ○ cold sores
- ○ connective tissue disorder
- ○ diabetes
- ○ G.I. ulcers
- ○ hepatitis
- ○ impaired liver function
- ○ irritable bowel syndrome
- ○ jaundice
- ○ joint replacement surgery
- ○ osteoporosis
- ○ persistent cough
- ○ radiation therapy
- ○ recurrent infections
- ○ recent weight loss
- ○ sinus trouble
- ○ sleep apnea
- ○ substance abuse
- ○ systemic lupus
- ○ prostate issues

Have you experienced an unusual reaction to any of the following?

- ○ Anaprox
- ○ Aspirin
- ○ Codeine
- ○ Erythromycin
- ○ Iodine
- ○ Latex
- ○ Nitrous Oxide
- ○ Penicillin
- ○ Percodan
- ○ Sulfa
- ○ Synalgos
- ○ Tetracycline
- ○ Tylenol
- ○ Valium
- ○ Vicodin

Are you required, due to health, to restrict your work or activity in any way? ○ Yes ○ No

For women, check all that apply:

- ○ I am pregnant
- ○ I am nursing
- ○ I am taking birth control pills

Do you have any disease, problem or condition not listed above? *Please explain* ____________________

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I understand that my account is payable at the time of service, unless other arrangements have been made for payment. I also understand that I assume responsibility for payment of any charges not covered by insurance, and that I will be liable for all cost of collection including attorney fees, together with interest accruing at the rate of 1% per month, with a minimum monthly charge of $2.50, for all accounts 90 days or more overdue. A charge of $15.00 will be charged for all returned checks.

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status. *Moreover, I accept the courtesy that BlackBeagle's office offers in submitting insurance claims on my behalf. I hereby authorize the release of any information relating to said claims, and authorize as well, payment directly to BlackBeagle's office of the group insurance benefits, otherwise payable to me. Moreover, I understand that this filing is done as a courtesy and that I am responsible for all cost of dental treatment.*

Patient Signature ____________________ **Date** ____________________