



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:

- | | |
|---|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Heart Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No COPD, emphysema, or other Lung Disease |
| <input type="checkbox"/> Yes <input type="checkbox"/> No High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No Asthma |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Low Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No Bisphosphonate Medication |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Heart Murmur | <input type="checkbox"/> Yes <input type="checkbox"/> No Tuberculosis |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Heart Attack | <input type="checkbox"/> Yes <input type="checkbox"/> No Allergies or Hives |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Angina Pectoris/Chest Pain | <input type="checkbox"/> Yes <input type="checkbox"/> No Sinus Issues |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Pacemaker | <input type="checkbox"/> Yes <input type="checkbox"/> No Hay Fever |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Rheumatic Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No Stroke |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes | |

Latest HbA1c & date: _____

- | | |
|---|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Metabolic Syndrome | <input type="checkbox"/> Yes <input type="checkbox"/> No Epilepsy or Seizures |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Obesity | <input type="checkbox"/> Yes <input type="checkbox"/> No Cognitive Impairment |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Hypoglycemia | <input type="checkbox"/> Yes <input type="checkbox"/> No Psychiatric Treatment |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Ulcers (Stomach or Intestinal) | <input type="checkbox"/> Yes <input type="checkbox"/> No Alzheimer's Disease |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Kidney Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No Cancer |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Kidney Dialysis | <input type="checkbox"/> Yes <input type="checkbox"/> No Chemotherapy (Cancer, Leukemia) |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Bladder Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No X-Ray or Radiation Treatment |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Liver Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No Problems in Healing |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Hepatitis | <input type="checkbox"/> Yes <input type="checkbox"/> No Arthritis |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No Fainting or Dizzy Spells |
| <input type="checkbox"/> Yes <input type="checkbox"/> No AIDS/HIV Positive | <input type="checkbox"/> Yes <input type="checkbox"/> No Acid Reflux |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Osteoporosis or Osteopenia | <input type="checkbox"/> Yes <input type="checkbox"/> No Dry Mouth |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Cold Sores/Fever Blisters | <input type="checkbox"/> Yes <input type="checkbox"/> No Glaucoma |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Drug Addiction | <input type="checkbox"/> Yes <input type="checkbox"/> No Blood Diseases |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Joint Replacement | <input type="checkbox"/> Yes <input type="checkbox"/> No Leukemia |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Organ Transplant | <input type="checkbox"/> Yes <input type="checkbox"/> No Hemophilia |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Thyroid Disease (or Goiter) | <input type="checkbox"/> Yes <input type="checkbox"/> 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?

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 use 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 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



Four Rivers Periodontics & Implant Specialists

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

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



Four Rivers Periodontics & Implant Specialists

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: _____