INTRODUCTIONS

Patient's Name _____ Nickname? _____

Address: _____

SS# _____-_____-_____ Birth date: _____ This information is necessary for patient identification.

Phone - H(_____)_____ W(_____)_____ Cell (_____)_____

Marital / Partner Status (S - M - P) Emergency Contact: _____

Employer: _____

All personal information is held in Strict Confidentiality in accordance with HIPAA and all State & Federal Regulations.

GETTING TO KNOW YOU

Why do you seek periodontal or implant care now? _____

Whom can we thank for referring you? _____ Family____ Friend____ Doctor _____

How long since your last dental visit? _____ How long since your last cleaning? _____

Is there anything you would like to change about your smile, or any other part of your mouth? What would that be?

_____

Please describe your long-term goals for the health of your mouth and teeth _____

What dental services have you had? Please indicate with a ✔

Cleanings _____ Extractions _____ Root Canals _____ Caps or Crowns _____ Braces _____ Bleaching _____

Cosmetic Bonding _____ Implants _____ TMJ Therapy _____ Treatment of Gum Disease _____ Gum surgery _____

Other: _____Have you postponed recommended treatment? _____ Tell me more about that _____

_____

Have you had problems or undesirable experiences with previous dental treatments? _____

What can we do to make you most comfortable? _____

Is there anything else you would like us to be aware of? _____

_____

Do you clench or grind your teeth? _____

How often do you use your Toothbrush? _____ Type _____Toothpaste?_____ Brand_____

Floss? _____ Type _____ Toothpick? _____ Other? _____

Are you on a special diet? _____ Please describe _____

Notations (for office use):

Dr's Initials

MEDICAL HISTORY

Name:_____Date of Birth:_____Today's Date:_____

Address: _____ Home #: _____Work #: _____

General **[Please circle one]**

Have you had any serious illness, operations or been hospitalized? Yes No
If yes, please explain _____
_____

Are you currently under the care of a physician? Yes No
If yes, for what condition _____
_____

Do we have your permission to consult with your physician? Yes No
Medical Doctors Name _____Phone #:_____
Date of last physical:_____
Are you aware of any changes in your general health in the last year?_____

Do you currently have, or have a past history of, any of the following conditions: **[Please circle one]**

Diabetes	Yes No	Impaired Eyesight; Glaucoma	Yes No	
Diabetes in family	Yes No	Hearing Aid or Hearing disorder?	Yes No	
Thyroid disease	Yes No	Liver Condition,: Jaundice; Hepatitis A,B, or C; Cirrhosis	Yes No	
Arthritis	Yes No	Kidney Condition; Shunt; Dialysis;	Yes No	
Venereal Disease	Yes No	Any Artificial Joints? (Hip or Knee)	Yes No	
Epilepsy; Seizures	Yes No	Positive HIV; AIDS; or AIDS Related Complex?	Yes No	
Ulcers	Yes No	Frequent Mouth Sores or Lesions	Yes No	
Cancer	Yes No	Woman: Are you Pregnant? Yes No	Nursing?	Yes No

If yes for cancer, type:_____ Chemotherapy or Radiation Yes No
Are you taking or have you taken any medications for osteoporosis or osteopenia, i.e. Boniva, Actonel, Fosomax ? Yes No

Circulation:

Arterio/Atherosclerosis	Yes No	Heart Surgery (circle) Bypass , Valve Replacement, Other	Yes No
High/Low Blood Pressure	Yes No	Rheumatic Fever; Rheumatic Heart Disease; Scarlet Fever	Yes No
Blood/Bleeding Disorder	Yes No	Heart Murmur; Mitral Valve Prolapse	Yes No
Blood Transfusion	Yes No	Pacemaker if yes, year placed_____	Yes No
Stroke	Yes No	Heart Trouble; (circle) Heart Attack; Angina (chest pain)	Yes No

Respiratory:

Chronic Lung Disease	Yes No	Tuberculosis	Yes No
Asthma	Yes No	Ever Exposed to TB or Family Member with TB	Yes No
Hay Fever/allergies	Yes No	Persistent Cough or Cough Up Blood	Yes No
Emphysema	Yes No	Sinus Trouble	Yes No

Currently use tobacco Products? Yes No If yes, how much per day_____For how long?_____
Past history of tobacco use? Yes No If yes, when quit_____

Allergies:

If allergic to or have had previous reaction to the following (please circle any/all that apply)
Aspirin Penicillin Tetracycline Erythromycin Sulfa Latex
Codeine Dental anesthetic other:_____
Have you or are you being treated for any drug or alcohol addiction? Yes No
Are you taking oral contraceptives or other hormonal therapy? Yes No

Medications:

Please list any Prescription, over the counter medications or supplements you are currently taking including dosage.

_____

_____

I certify that the above information is correct and will notify my Periodontist or Hygienist of any changes

Signature:_____Reviewed by:_____

ACCOUNT AND DENTAL BENEFIT INFORMATION

As a courtesy to our patients, we accept assignment of dental benefits. However, ***please note that it is our policy that payment for your initial examination be paid in full at your first appointment***. Additional information regarding our acceptance of insurance assignment is outlined under the "*Acknowledgement and Release"* section of this form. If you would like us to file claims for your treatment in our office with your dental benefits carrier, please fill out the information below. We have also enclosed a copy of our Notice of Privacy Practices for your personal records.

Benefits Through Your Employer

Subscribers Name _____ Pt ID or SS#_____ Birth date _____

Employers Name _____

Insurance Co. Name _____ Claims Address _____

Insurance Co. Phone # _____ Group # _____

Benefits Through Another Person's Employer

Subscribers Name _____ Pt ID or SS#_____ Birth date _____

Employers Name _____

Relationship to Patient _____ Address if different _____

Insurance Co. Name _____ Claims Address _____

Insurance Co. Phone # _____ Group # _____

ACKNOWLEDGEMENT AND RELEASE

To the best of my knowledge the above information noted (page 2,3) is correct. I will inform this office of any changes.

I **Consent** to the taking of photographs and X-rays before, during and after treatment and to the use of same by the doctor in scientific presentations or demonstrations.

Insurance: We provide services for our patients with the understanding that they are responsible for payment in accordance with our financial policy. We will prepare and submit forms and reports to assist you in obtaining maximum benefits available, but in no case are treatment recommendations or fees affected by the presence or absence of insurance benefits. Treatment recommendations are based on your dental needs and desires and are not a reflection of your dental benefits. Neither Dr. Butler nor Dr. O'Neal will compromise the care that they provide because of inadequate insurance benefits. Your dental benefits are a contract between you, your employer and the insurance company. We are not providers, members or have any association with any insurance organizations. I authorize the release of any pertinent information to the insurance company that is necessary to process my claims and I authorize my insurance benefits to be paid directly to the dentist if assignment of benefits is allowed.

Collections: In the event the balance becomes more than 60 days overdue, billing may be turned over to an outside collection agency. The responsible party listed above agrees to pay interest, collection and other legal expenses related to collection of fees owed. Waiver of any breach of any time or condition shall not constitute a waiver of any further term or condition.

Signature _____ Date _____

(parent or guardian if patient is a minor)

Patient Information and Directions:

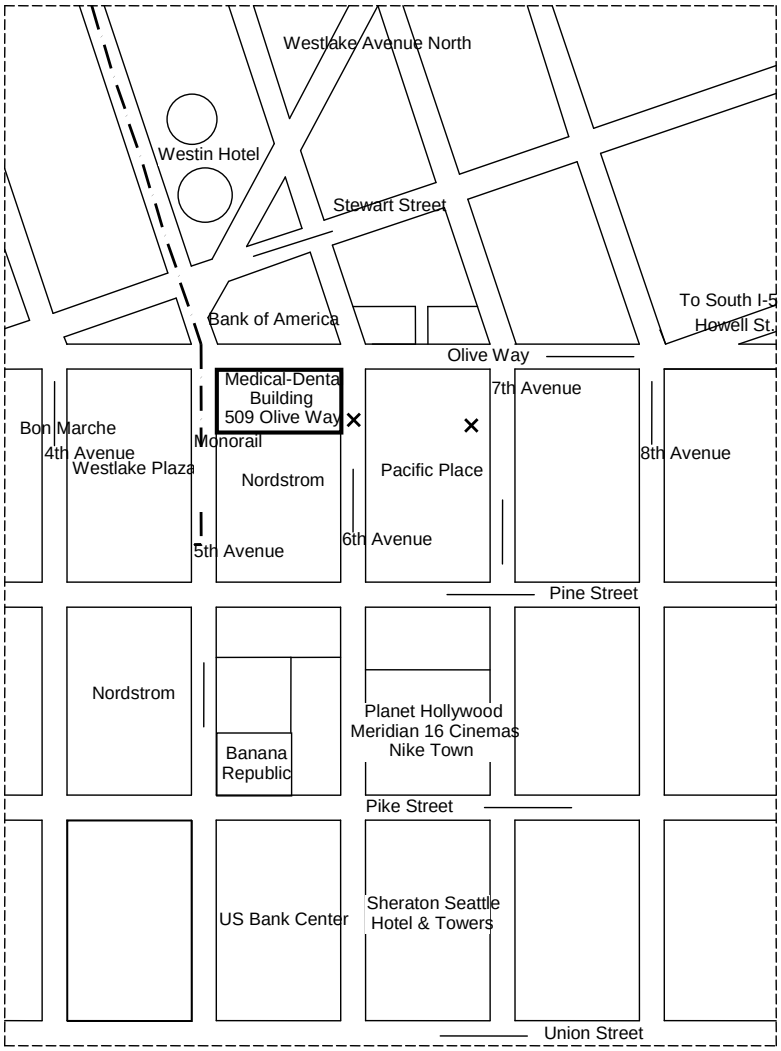
An initial examination is necessary prior to beginning treatment. Additional x-rays may be required to properly evaluate, diagnose and treat your periodontal condition. You may be asked to set up an appointment with NW Radiography for additional x-rays. We request that you please provide us with 24 hours notice if you need to cancel or reschedule your examination appointment.

Parking is available in the Pacific Place parking garage and the Medical Dental Building parking garage.

From I-90: take I-5 to the Madison exit and turn left. Turn right at 6th Avenue; follow 6th and turn right into the Pacific Place parking garage (just past Pine and before Olive).

From the South: take I-5 to the Seneca exit, turn right at 6th Avenue; follow 6th and turn right into the Pacific Place parking garage (just past Pine and before Olive).

From the North: take I-5 to the Stewart and Denny exit; follow Stewart to 7th and turn left; follow 7th past Olive and turn right into Pacific Place, or continue on and turn right on to Pine, then right on to 6th and then turn right into the Pacific Place parking garage (just past Pine and before Olive).



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