Legacy Periodontics & Implant Center

555 W Wheatland Road,Duncanville TX, 75116

Patient Dental & Medical Health History Information

Today's Date:_____

To our patients: Please know that we may ask follow- up questions to make sure we have all of the correct information to treat you.

PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle Int: _____Date of Birth: _____

Gender: M☐ F☐ Other: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____

Mailing Address: _____ (Street, City, State, Zip)

Emergency Contact: Name: _____ Relationship: _____ Phone: _____

If you are completing this form for another person. What is your name and relationship to that person?

Name: _____ Relationship: _____

If executing this form as the patient's personal representative, I represent and warrant that I have full legal right and authority to consent to the performance of any procedure(s) on this patient.If for any reason I no longer have such legal right and authority, I will immediately notify the practice in writing.

When was your last dental exam? _____ What was done? _____

When was the last time you had dental x-rays taken?_____ Who is your general dentist? _____

Please mark an •x· In the box ONLY If this applies to you. Does

	Yes	No		Yes	No
it hurt to chew,bite or swallow?	☐	☐	Have you ever had a serious injury to your head or mouth?	☐	☐
Do your gums bleed when you brush or floss your teeth?	☐	☐	If yes, please describe what happened and when it happened:		
Have you ever had (gum) treatments like scaling and root planning?	☐	☐	_____		
Do you have, or have you had. any sores or growths In your mouth?	☐	☐	Have you ever had problems with dental treatment in the past?	☐	☐
Do you clench or grind your teeth?	☐	☐	If yes, pleasedescribe whathappened:		
Does your Jaw click, pop or hurt?	☐	☐	_____		
Do you have earaches or neck pains?	☐	☐	Have you ever had a reaction to dental anesthesia?	☐	☐
Is it hard to open your mouth?	☐	☐	If yes, please describe what happened:_____		

Have you ever experienced any of these sleep-related breathing disorders? ☐ Mouth breathing ☐ Snoring ☐ Sleep Apnea

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Pharmacy: _____ Address: _____

Phone Number: _____

MEDICATIONS & OTHER PRODUCTS/SUBSTANCES/DENTAL HISTORY & SYMPTOMS

Please use an •x· to mark your answers to the following questions.

	Yes	No
Are you currently experiencing any dental pain or discomfort?	☐	☐
Are you taking any blood thinners	☐	☐
Are you taking any medication to treat osteoporosis or Paget's disease?	☐	☐
Are you taking, or scheduled to take, IV medication to treat: hypercalcemia or treatment for Paget's disease, multiple myelomia or cancer?	☐	☐
Are you taking Hormonal replacements?	☐	☐
Do you use any form of smoking/tobacco/nicotine products?(cigarettes,snuff,chew,vape)	☐	☐
Do you use controlled substances (drugs), including marijuana, for either medicinal or recreational reasons?	☐	☐

*If yes, what substances?_____ ☐ Daily ☐ Several times per week ☐ Weekly ☐ Occasionally

Was the substance prescribed by a doctor? ☐ Yes ☐ No If Yes, for What reason(s)?_____

How many alcoholic beverages do you have per week?_____

Do you take any other prescriptions and/or over-the-counter medicine(s), vitamins, herbs and/or supplements? If yes, please list them here and include dose and frequency

WOMEN ONLY: Are you: ☐ Taking birth control pills? ☐ Pregnant? If yes. number of weeks:_____ ☐ Nursing? If yes. number of weeks:_____

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ALLERGIES Please use an X to mark your answers to the following questions: Are you allergic to or have you had an allergic reaction to:

	Yes	No		Yes	No
Aspirin	☐	☐	Sulfa drugs	☐	☐
(Barbiturates, sedatives or sleeping pills Codeine or other)			Metals	☐	☐
Narcotics	☐	☐	Latex (rubber)	☐	☐
Hay fever/seasonal allergies	☐	☐	Penicillin or; other antibiotics	☐	☐
Local anesthetics	☐	☐	Other:_____		

MEDICAL & SURGICAL HISTORY

Date of last physical exam:_____ Doctor's Name:_____ Phone:_____

Please use an .. X .. to mark your answers to the following questions:

	Yes	No
Are you in good physical health?	☐	☐
Has a physician or previous dentist recommended that you take antibiotics before having dental work done?	☐	☐
If yes, do you need to be premedicated? ☐ Yes ☐ No What antibiotic do you take?_____		
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐
If Yes, Please explain:_____		
Have you had any type of (either; total or partial) joint replacement surgery (such as; hip, knee, shoulder, elbow, finger, etc.)?	☐	☐
If Yes, Name of Orthopedic Surgeon:_____ Phone Number:_____		
Have you had a heart valve replacement or heart surgery?	☐	☐
If Yes, Name of Cardiologist:_____ Phone Number:_____		
Have you had an organ or bone marrow/stem cell transplant?	☐	☐
In the past 30 days have you experienced and unusual. unknown health conditions such as fainting for no reason or finding it hard to catch your breath?	☐	☐

MEDICAL HISTORY DETAILED

Please use an **X** to mark your answers to the following questions. Do you have, or have you been diagnosed with any of the following condition?

	Yes	No		Yes	No		Yes	No
Pacemaker/implanted defibrillator	☐	☐	Anemia	☐	☐	Gastrointestinal disease	☐	☐
Artificial (prosthetic) heart valve	☐	☐	Blood transfusion	☐	☐	G.E. reflux/persistent heartburn	☐	☐
Previous infective endocarditis	☐	☐	Hemophilia	☐	☐	Glaucoma	☐	☐
Repaired CHD	☐	☐	High or low blood pressure	☐	☐	Rheumatoid Arthritis	☐	☐
Arteriosclerosis	☐	☐	Anxiety	☐	☐	Diabetes ☐ Type-I ☐ Type-II	☐	☐
Coronary artery disease/heart disease	☐	☐	Depression	☐	☐	Eating disorder	☐	☐
Congestive heart failure	☐	☐	Epilepsy	☐	☐	Frequent infections	☐	☐
Damaged heart valves	☐	☐	Mental health disorders	☐	☐	Immune deficiency	☐	☐
Congenital heart disease (CHD)	☐	☐	Neurological disorders	☐	☐	Kidney problems	☐	☐
Heart attack (**Date:_____**)	☐	☐	Post-traumatic stress disorder	☐	☐	Osteoporosis	☐	☐
Heart murmur/rhythm disorder	☐	☐	Brain injury or Concussion	☐	☐	Sexually Transmitted Infection (STI)	☐	☐
Stroke (**Date:_____**)	☐	☐	Thyroid problems	☐	☐	AIDS or HIV Infection	☐	☐
Emphysema	☐	☐	Lupus	☐	☐	Hepatitis	☐	☐
Asthma (COPD)	☐	☐	Jaundice or Liver disease	☐	☐	Sinus trouble	☐	☐
			Tuberculosis	☐	☐	Bronchitis	☐	☐
			Herpes	☐	☐			

Cancer? ☐ Yes ☐ No Type:_____ Date of diagnosis:_____ Chemotherapy:_____

Do you have any disease, condition, or problem that's not listed here? ☐ Yes ☐ No If so, please explain below:

_____

NOTE: It's Important for both the doctor and patient to talk honestly about the patients health before dental treatment starts. I have answered the above questions completely,accurately and to the best of my ability. I agree and understand that all electronic signatures are legal and the equvilant of my manual/handwritten signature, and i consent to be leaglly bound to this agreement.

X_____ _____

Signature (patient or responsible party if patient is a minor) **Date**

Office Use Only

FOR COMPLETION BY STAFF

Medical Alert Reviewed by:_____ Premedication Needed:_____

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☐ **COPY OF INSURANCE CARD ON FILE**

PLEASE PRINT CLEARLY

Patient Name:_____

Person responsible for this account:_____ Relation to patient:_____

Do you have dental Insurance? ☐ **Yes** ☐ **No**

PRIMARY DENTAL INSURANCE

Policy Holder:_____

Birth date:_____ SS#_____

Insurance:_____

ID#_____ Group#_____

SECONDARY DENTAL INSURANCE

Policy Holder:_____

Birth date:_____ SS#_____

Insurance:_____

ID#_____ Group#_____

I certify that the above information is true. I agree to be responsible for the services provided and all charges whether or not paid by my insurance carrier. I authorize disclosure of any portion of the patients records necessary to obtain payment from my insurance carrier for inquiries regarding treatment. I hereby assign all dental benefits, including private insurance and other health plans to which I am entitled: to the treating provider. This assignment will remain in effect until revoked by me in writing and that a copy of this assignment will be considered as valid as the original. **I agree and understand that all electronic signatures are legal and the equvilant of my manual/ handwritten signature, and i consent to be leaglly bound to this agreement.**

X_____ _____

Signature (patient or responsible party if patient is a minor) **Date**

FINANCIAL POLICY:

PATIENTS WITH INSURANCE COVERAGE:

As a courtesy to our patients we would be glad to help you obtain the maximum benefit from your insurance. Per-treatment estimates and claims submission will be done as a courtesy to you. However, you are responsible for the full cost of treatment.

Portions of the bill may not be paid by the insurance company and are to be paid by the patient. Often there is a co-payment required by you as per your agreement with your insurance. Even if you have double coverage (this is possible if you and your spouse both have coverage), there may still be a portion that will be your responsibility.

If you are having treatment over a period of time, we appreciate payment during the course of treatment unless other payment arrangements have been made. Our office staff will assist you with payment arrangements if needed. For your convenience we accept: Visa, MasterCard, Discover, American Express, cash or check payments.

PATIENTS WITHOUT INSURANCE COVERAGE:

Patients without insurance coverage are requested to pay for all services at the time of services and during the course of treatment unless a payment arrangement has been arranged.

ADDITINAL POLICIES:

Appointments canceled with less than 48 hours notice are subject to a cancellation fee of $60. Appointments made for surgical procedures may require a 40% appointment deposit and a minimum of 72 hours cancellation notice (See appointment deposit form) Checks returned by your bank are subject to a $30 processing charge (which reflects the bank charge to this office)

Accounts unpaid after 30 days from the date of billing or insurance claim processing are subject to a fiance charge at a rate of 2% of the balance total per month unless payment arrangements have been made. If your account if referred for collections, you will be responsible for additional collections cost in the amount of 30% of the outstanding balance, together with court cost and reasonable attorney fees.

I agree and understand that all electronic signatures are legal and the equvilant of my manual/handwritten signature, and i consent to be leaglly bound to this agreement.

☐ **I HAVE READ, UNDERSTAND AND AGREE TO THIS OFFICES FINANCIAL POLICY.**

X_____ _____

Signature (patient or responsible party if patient is a minor) **Date**

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Effective April 14, 2003, the federal HIPPA privacy rule requires our office to comply with certain legal requirements designed to protect your personal health information (PHI). HIPPA gives individuals the right to request a restriction on uses and disclosures of PHI. The individual is also provided the right to request confidential communications of PHI remade by alternative means, such as sending correspondence to the individual's office instead of home. We may need your written authorization to release PHI even if you are the one requesting the release.

☐ I have received a copy of this office's Notice of Privacy Practices.

I may be contacted in the following manner. Check all that apply:

☐ Home Phone	☐ OK to leave a detailed message.	☐ Leave a message with call back number only.
☐ Work Phone	☐ OK to leave a detailed message.	☐ Leave a message with call back number only.
☐ Cell Phone	☐ OK to leave a detailed message.	☐ Leave a message with call back number only.

The following person/people may receive disclosure of my protected health information:

X_____ _____

PATIENT/GUARDIAN SIGNATURE **Date**

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, By acknowledgment could not be obtained because:

☐ Individual refused to sign ☐ Communication barriers prohibited obtaining the acknowledgment

☐ Other (Please specify) ☐ An emergency situation prevented us from obtaining acknowledgment

We would like to take this opportunity to welcome you to our office and assure you that we will do our utmost to provide you with the best care possible.