SCOTT M. DOWELL, DDS, MS
PERIODONTICS
& DENTAL IMPLANTS

ASA:_____ Chart #:_____

PATIENT INFORMATION
THE FOLLOWING INFORMATION IS CONFIDENTIAL AND FOR OUR RECORDS ONLY

Patient's Name _____
First Middle Initial Last

Date of Birth _____ Today's Date _____

Sex _____ Weight _____ Height _____ Social Security # _____

Circle One: Married Single Child Other_____

Spouse/Guardian Name _____

Residential Address: _____
Street

_____
City State Zip

Phone: _____ Cell: _____

Email: _____

Employed by _____

Name of Referring Dentist _____

How long have you been under his/her care? _____

Name and Address of Physician (Medical Doctor) _____

Physician's (Medical Doctor) Telephone _____

Why were you referred to a periodontist? _____

Are you covered by Dental Insurance? _____

Name and Address of Carrier _____

_____

Group Number _____ ID Number _____

Person Responsible for This Account _____

Date of Birth _____ Social Security # _____

Employed by _____

Patient's Relationship to Insured _____

Person to Notify in Case of Emergency _____

GENERAL HEALTH

Circle One: What is your estimation of your general health? GOOD – FAIR – POOR

Circle One:

Yes No Are you now under the regular care of a physician?

If so, for what? _____

When was your last physical examination? _____

Yes No Have you had any major operations, hospitalization or illnesses?

If so, for what? _____

Yes No Are you taking any pills, medication or drugs?

If so, please list. _____

_____

Yes No Have you had any unusual reaction or allergies to any medications or foods?

If so, please list. _____

Have you ever had a reaction to any of the following: (PLEASE CHECK)

____ Penicillin
____ Sulfa drugs
____ Codeine
____ Aspirin
____ Bisphosphonates
____ Sleeping pills (barbiturates)
____ Tetracycline
____ Dental anesthetic (Novocain)
____ Nitrous oxide (laughing gas)
____ Latex

Yes No Do you smoke? If so, how many a day? _____

Yes No Do you drink alcohol?

Yes No Are you on a diet of any kind?

Yes No Has any member of your family had tuberculosis, diabetes, heart disease, allergies, bleeding problems or cancer? If yes, who? _____

Do you have or have you ever had: (PLEASE CHECK)

____ Rheumatic fever
____ Heart murmur
____ Heart attack
____ Arteriosclerosis
____ Diabetes
____ Stroke
____ Abnormal thirst
____ Tumors or growths
____ X-ray or radiation therapy
____ Problems in healing
____ Frequent headaches
____ Allergies
____ Glaucoma
____ Frequent fractures or dislocations
____ Condition requiring cortisone or other steroids
____ Hepatitis, jaundice, or other liver disease
____ Shortness of breath or chest pains
____ Tuberculosis
____ Anxiety
____ Ulcers (stomach or duodenal)
____ Kidney or bladder trouble
____ High or low blood pressure
____ Thyroid or parathyroid disease
____ Asthma or difficulty breathing
____ Anemia or other blood disorder
____ Frequent vomiting or diarrhea
____ Arthritis or rheumatism
____ Painful or swollen joints
____ Rashes or skin disorders
____ Dizziness or light headedness
____ Sinus problems
____ Sexually related disease
____ Swelling of the hands, feet or eyes
____ Epilepsy, seizures, or fainting
____ Cancer
____ Cognitive impairment
____ Obesity

Yes No Are you excessively nervous or depressed?
Yes No Have you ever been treated for nervous or mental disorders?
Yes No Do you find it necessary to sleep using two pillows?
Yes No Have you recently gained or lost excessive amounts of weight?
Yes No Have you had abnormal bleeding after a cut or a tooth extraction?

WOMEN ONLY:

Yes No Are you pregnant? Due date:
Yes No Are you taking birth control pills?
Yes No Have you reached menopause?

DENTAL HEALTH

Yes No Do you consider yourself in good dental health?
Yes No Do you think that your teeth are affecting your health in any way?
Yes No Are you dissatisfied with the appearance of your teeth?
Yes No Are you dissatisfied with your chewing ability?
Have you ever had:
____ Orthodontic treatment (braces)
____ Oral surgery (extraction, etc.)
____ Periodontal treatment
____ Your teeth ground or bite adjusted
____ A bite plate or other appliance
Yes No Have you noticed any loosening of your teeth?
Yes No Does food tend to become caught between your teeth?
Yes No Do you suffer from pain and/or swelling of your gums?
Yes No Do your gums often bleed when you brush your teeth?
Yes No Do you have any unpleasant odor or taste in your mouth?
Yes No Are you missing any teeth?
Reasons: Decay ( ) Gum disease ( ) Other ( )
Yes No Have missing teeth been replaced?
Yes No Do you ever have any soreness, pain, clicking or popping in the area in front of your ears?
Do you:
____ Clench or grind your teeth while awake or asleep?
____ Bite your lips or cheeks regularly?
____ Hold foreign objects with your teeth?
____ Breathe primarily through your mouth?

When did you last have your teeth cleaned before this appointment? _____

How long before that? _____

How often do you see your dentist? _____

How often and when do you brush your teeth? _____
Do you use: Hand toothbrush ( ) Electric toothbrush ( )
Is your toothbrush: Soft ( ) Medium ( ) Hard ( )
What else do you use to clean your teeth? (floss, toothpick, Waterpik, etc.) _____

How often? _____

Yes No Do you feel apprehensive when you are having a dental treatment?
Yes No Does the fear of pain make you postpone your dental treatment?
Yes No Is it important to you to keep your teeth?
Yes No Would you spend fifteen minutes a day in order to keep your natural teeth?

Consent for Services

In consideration of both this office and other patients this office services, patients missing multiple appointments without 24 hours' notice are subject to dismissal at the discretion of this office.

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon payment by the patient for their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that the fee estimate listed for the prescribed dental care can only be extended for a period of six months from the date of the patient examination, at which time charges for care will be adjusted to the amount that is current for the procedures listed.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ _____

Name of Patient or Legal Guardian Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgement *

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

_____

Please Print Name

_____

Signature

_____

Date

For Office Use Only

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

Individual refused to sign

Communications barriers prohibited obtaining the acknowledgement

An emergency situation prevented us from obtaining acknowledgement

Other (Please Specify) _____