

# Welcome to Sedona Periodontics

In order for us to better serve you, please complete the following information:

## PATIENT INFORMATION

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Driver's Lic # \_\_\_\_\_  
 \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_ Social Security # \_\_\_-\_\_\_-\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Zip \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_-\_\_\_-\_\_\_ Cell Phone (\_\_\_\_) \_\_\_-\_\_\_-\_\_\_

Work Phone (\_\_\_\_) \_\_\_-\_\_\_-\_\_\_ E-mail address \_\_\_\_\_

Check Appropriate:  Minor  Single  Married  Divorced  Widowed  Separated

**Whom May We Thank for Referring You?** \_\_\_\_\_

**Current General Dentist** \_\_\_\_\_ Phone Number \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relation \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_-\_\_\_-\_\_\_

Preferred Pharmacy \_\_\_\_\_ Location \_\_\_\_\_

## RESPONSIBLE PARTY

Responsible Account Holder \_\_\_\_\_ Relation to Patient \_\_\_\_\_

Date of Birth \_\_\_/\_\_\_/\_\_\_ Social Security # \_\_\_-\_\_\_-\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Zip \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_-\_\_\_-\_\_\_ Cell Phone (\_\_\_\_) \_\_\_-\_\_\_-\_\_\_

Occupation \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_-\_\_\_-\_\_\_

## INSURANCE INFORMATION

Name of Insured \_\_\_\_\_ Relation to Patient \_\_\_\_\_

Date of Birth \_\_\_/\_\_\_/\_\_\_ Social Security # \_\_\_-\_\_\_-\_\_\_ Date Employed \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_-\_\_\_-\_\_\_

Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Union or Local # \_\_\_\_\_ Address \_\_\_\_\_  
 \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

## ADDITIONAL INSURANCE

Name of Insured \_\_\_\_\_ Relation to Patient \_\_\_\_\_

Date of Birth \_\_\_/\_\_\_/\_\_\_ Social Security # \_\_\_\_\_ Date Employed \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_-\_\_\_-\_\_\_

Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Union or Local # \_\_\_\_\_ Address \_\_\_\_\_  
 \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

## MEDICAL HISTORY

Physician's Name \_\_\_\_\_ Date of last visit \_\_\_\_\_

Have you had any serious illnesses or operations?  Yes  No If Yes, describe \_\_\_\_\_

Have you ever had a blood transfusion?  Yes  No If yes, give approximate dates \_\_\_\_\_

(Women) Are you pregnant?  Yes  No Due date: \_\_\_\_\_ Nursing? Yes No Taking birth control pills? Yes No

CONDITION	Y	N	CONDITION	Y	N	CONDITION	Y	N	CONDITION	Y	N
Allergies, hay fever sinusitis			Circulatory problems			Jaundice			Stroke		

Anemia			Cortisone treatments			Liver disease			Swelling of feet or ankles		
Arthritis, Rheumatism			Cough, persistent or bloody			Low blood pressure			Thyroid problems		
<b>CONDITION</b>	<b>Y</b>	<b>N</b>	<b>CONDITION</b>	<b>Y</b>	<b>N</b>	<b>CONDITION</b>	<b>Y</b>	<b>N</b>	<b>CONDITION</b>	<b>Y</b>	<b>N</b>
Artificial heart valves			Diabetes			Kidney disease			Tonsillitis		
Artificial joints			Emphysema			Mitral valve prolapse			Tuberculosis		
Apnea (Sleep obstruction)			Epilepsy			Pacemaker			Tumor or growth on head or neck		
Asthma- Required Hospitalization?			Fainting			Radiation treatment					
Last episode?			Glaucoma			Respiratory disease			Ulcer		
Bleeding abnormally with extractions or surgery			Headaches			Rheumatic fever			Venereal disease		
			Heart murmur			Scarlet fever			Weight loss (unexplained)		
			Heart problems			Shortness of breath			Bisphosphonate use (Actonel, Fosamax, etc)		
Blood disease or clotting			Hepatitis Type ____			Sinus trouble					
Cancer			Herpes			Sickle cell anemia			Fen-Phen use?		
Alcohol/Substance Abuse			High blood pressure			Skin rash			Wear contact lenses?		
Chemotherapy			Immune Deficiency			Slow healing wounds			Wear hearing aids?		

List medications you are currently taking: \_\_\_\_\_

Allergies (ie. penicillin, aspirin, latex): Yes No Specify: \_\_\_\_\_

Do you smoke tobacco products? Yes No Specify: \_\_\_\_\_

### DENTAL HISTORY

CONDITION	Y	N	CONDITION	Y	N
Bad breath					
Blisters on lips or mouth					
Burning sensation on tongue			Orthodontic treatment		
Food collection between the teeth			Periodontal treatment		
Clench or grind teeth			Sensitivity to pressure or irritants (cold, heat or sweets)		
Growths or sore spots in your mouth			Have you needed sedation in the past for dental work? Nitrous Oxide (laughing gas) Oral or I.V. (intravenous) sedation? General anesthesia?		
Gums swollen, tender or bleeding					
Jaw popping, pain, locking or tiredness					
Lip or cheek biting					
Loose teeth or broken fillings					
Mouth breathing, Sleep apnea					

Have you ever had an allergic reactions to local or general anesthetics? Yes No Explain: \_\_\_\_\_

Have you had trouble from previous dental care? Yes No Explain: \_\_\_\_\_

### AUTHORIZATION AND RELEASE

I have read and answered the above questions to the best of my knowledge. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I authorize the doctor to release all information necessary to secure the payment of benefits. I

understand that I am financially responsible for all charges whether or not paid by my insurance. I authorize the use of this signature on all insurance submissions.

\_\_\_\_\_  
Signature of patient (or parent, if minor) \_\_\_\_\_  
Date