TEMPE IMPLANTS AND PERIODONTICS, LLC

Practice Limited to Periodontics and Implants

The following information is necessary to thoroughly evaluate your health. This information will be kept strictly confidential and will not be released to anyone. Thank you for taking the time to complete this questionnaire.

HEALTH HISTORY

Name:_________________________ Birth date:_____________ Date:____________________

Circle the answer which applies:

1. Have you been under the care of a physician or hospitalized in the past year? Yes No
   Date of last examination________________________
   Name and address of physician________________________________
2. Are you taking or have you recently taken *any* prescription, OTC or herbal medication? Yes No
   Please list:

3. Are you allergic to or have you reacted adversely to any of the following medications? Yes No
   Aspirin_____ Codeine_____ Penicillin_____ Local anesthetics_____ Latex _____Other medications__________

4. Do you have or have you had any of the following:

Heart Disease	Yes	No
Heart surgery	Yes	No
Congenital heart lesions	Yes	No
Heart arrhythmia	Yes	No
Pacemaker/defibrillator	Yes	No
High Blood Pressure	Yes	No
Stroke / TIA	Yes	No
Respiratory problems	Yes	No
Asthma	Yes	No
Persistent cough	Yes	No
Hay fever or allergy	Yes	No
Sinus problems	Yes	No
Epilepsy	Yes	No
Fainting spells or seizures	Yes	No
Persistent headaches	Yes	No
Anemia	Yes	No
Abnormal Bleeding	Yes	No
Bruise easily	Yes	No
AIDS or HIV infection	Yes	No
Hepatitis or jaundice	Yes	No
Ulcers	Yes	No
Diabetes	Yes	No
Family history of diabetes	Yes	No
Thyroid problems	Yes	No
Arthritis or rheumatism	Yes	No
Joint replacement	Yes	No
Osteoporosis	Yes	No
Tumor or growths	Yes	No
Radiation or chemotherapy	Yes	No
Alcoholism or drug addiction	Yes	No
Nervousness	Yes	No
Glaucoma	Yes	No
Tobacco use	Yes	No

Women Only:

Are you pregnant	Yes	No
Do you take contraceptives	Yes	No
Have you reached menopause	Yes	No
Do you take hormones	Yes	No

DENTAL HISTORY

Why did you seek treatment at this time?________________________________

Do you see a dentist regularly? Yes No Dentist's Name________________________

When were your teeth last cleaned? ____________

Have you ever had periodontal or gum treatment before? Yes No When__________

Are you satisfied with the way your teeth look? Yes No Is it important for you to keep your own teeth? Yes No

Do you have or have you had?

a) Discomfort in the teeth, gums or jaw?	Yes	No
b) Bleeding gums?	Yes	No
c) Bad taste or bad breath?	Yes	No
d) Sensitivity to temperature or pressure?	Yes	No
e) Shifting of teeth within last 5 years?	Yes	No
f) Tired jaw or facial muscles?	Yes	No
g) Difficulty chewing?	Yes	No
h) Grinding or clenching of teeth?	Yes	No
i) Orthodontic treatment (braces)	Yes	No
j) Complications with dental treatment?	Yes	No

Which of the following do you use? Brush___Water Pik____Floss_____Mouth Rinse ____Toothpicks___Other_______

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health or if my medications change I will inform the doctor at the next appointment.

CONSENT FOR TREATMENT

I hereby authorize the doctor or his designee to utilize various diagnostic aids, medications and therapy that are deemed necessary or advisable for diagnosis and treatment. I also understand that therapeutic procedures may involve certain risks.

______________________ ______________________ ______________________

Tempe Implants & Periodontics, LLC

Drs. Peterson, Carlson and Holbrook

480-839-0841

PATIENT INFORMATION FORM

Date______________

Name____

Home Phone________________ Work Phone ______________ Cell Phone ________________

Address___________________________________ City_________________ Zip __________

Birth date____________ Marital Status ________Social Security #_______________________

Employer_________________________________ Occupation ___________________________

Work address______________________________ City_________________ Zip ___________

Spouse's Employer__________________________Occupation ___________________________

Spouse's work address________________________ City ________________ Zip ___________

Dentist_________________________ Years______

Referred by _____________________

Who will be responsible for this account? __________________________________

Emergency Contact and Phone #:______________________________

EMAIL ADDRESS:____________________________________

PATIENTS WITH DENTAL INSURANCE

Insured Person_________________________ID# or Social Security #______________________

Name of Plan________________________________ Plan # ___________________________

Do you have secondary dental insurance? ______________ *If yes, please continue:*

ID# or Social Security # _______________________ Birth date ________________________

Name of Plan ________________________________ Plan # ____________________________

FINANCIAL POLICY

It is our policy that billing procedures be clearly understood prior to the onset of treatment. Payment is expected at the time of treatment. Payment may be made by cash, personal check or credit card. Extended payments may be available through prior financial arrangements with our office manager. Any balance reflected in your statement is due within 10 days of receipt of your statement. Monthly bookkeeping fees may be applied to unpaid balances.

If you have dental insurance we will bill your primary insurance company, as a courtesy to you. Complete insurance information must be provided at the time of your first visit. All deductibles and copayments are due at the time of treatment. Please note that dental insurance is designed to help pay part of the cost of treatment. Your insurance contract is between you and your insurance company. The type of benefits in your contract depends on what your employer has negotiated and we cannot guarantee payment of your claims. We will be glad to assist you in filing for these benefits, but you are ultimately the one who is financially responsible for your treatment.

If you are unable to keep your appointment, please call us as soon as possible or leave a message if the office is closed. *A fee is assessed for missed/broken appointments without 24-hour notice.* Please understand this policy is necessary so that we may make this time available to other patients who are waiting for an appointment.

In the event that it becomes necessary to place an account in collections, the patient is responsible for any additional legal and collection related costs that may be incurred. By signing below you indicate that you have read the preceding and understand that periodontal services are rendered in accordance with these terms.

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

____
Patient Signature

____
Patient Signature