# UTC Periodontics and Oral Implantology

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**Please take a moment to enter or update your information to help us ensure the quality of your care is excellent.**
**PLEASE PROVIDE A PHOTO ID**

**Chart#:** _____
FOR OFFICE USE ONLY

**Patient Name:** _____* _____* ____ _____
Last First MI Preferred Name

**Title:** _____ **Gender:*** ◯ Male ◯ Female **Family Status:*** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

**Birth Date:*** _____ **SS#:** ___-__-____ **Prev. Visit:** _____

**Email Address:** _____ **Best time to call:** _____

**Phone:** _____* _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

**Address:** _____* _____
Address 1 Address 2

_____* _____* _____-____*
City State Zip Code

DO YOU HAVE ANY KNOWN ALLERGIES? YES NO If yes, Please state below

_____

_____

_____

_____

**Whom may we thank for referring you to our practice?**

☐ Dental Office: Dr. _____ ☐ Yellow Pages/Yelp/Social Media ☐ Internet
☐ Friend/Family:_____ ☐ School ☐ Insurance Company:_____
☐ Church ☐ Other:_____

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**PATIENT MEDICAL HISTORY**

Please list any and all medication(s) you are curently taking.

Please include:

NAME DOSAGE FREQUENCY, and DATE STARTED

_____

_____

_____

_____

_____

_____

_____

**DO YOU SMOKE? *** ◯ Yes ◯ No

**DO YOU HAVE HIGH BLOOD PRESSURE? *** ◯ Yes ◯ No

**HAVE YOU HAD ANY SURGERIES IN THE LAST 3 YEARS? *** ◯ Yes ◯ No

IF YES, PLEASE EXPLAIN:

_____

_____

_____

_____

_____

_____

_____

*BY SIGNING BELOW YOU AGREE TO ALL OF THE ABOVE STATEMENTS AND HAVE FILLED AND COMPLETED THIS FORM TO THE BEST OF YOUR KNOWLEDGE. IF ANY CHANGES SHOULD TAKE PLACE IT IS YOUR RESPONSIBILITY TO INFORM THIS PRACTICE AND THE PROVIDER SO THAT ANY UPDATES OR CHANGES MAY BE REFELECTED AND A NEW SIGNATURE MUST BE OBTAINED AT THAT TIME.

Signature _____ **Date** _____

## PATIENT MEDICAL HISTORY (CONTINUED)

**DO YOU HAVE ANY MEDICAL CONDITIONS THE DOCTOR SHOULD BE AWARE OF? ***

- ◯ ASTHMA
- ◯ ANXIETY
- ◯ DIABETES
- ◯ HIV
- ◯ HEPATITIS
- ◯ CANCER/RADIATION TREATMENT
- ◯ INFLUENZA
- ◯ HEART DISEASE
- ◯ PSYCHOLOGICAL CONDITIONS
- ◯ NEUROLOGICAL CONDITIONS
- ◯ OSTEOPEROSIS
- ◯ BACK PAIN
- ◯ NECK PAIN
- ◯ INJURIES:_____
- ◯ WOMEN ONLY: ARE YOU PREGNANT OR BREAST FEEDING? CIRCLE ONE YES NO
- ◯ OTHER:_____
- ◯ PLEASE CHECK HERE IF YOU DO NOT HAVE ANY OF THE ABOVE MENTIONED

*BY SIGNING BELOW YOU AGREE TO ALL OF THE ABOVE STATEMENTS AND HAVE FILLED AND COMPLETED THIS FORM TO THE BEST OF YOUR KNOWLEDGE. IF ANY CHANGES SHOULD TAKE PLACE IT IS YOUR RESPONSIBILITY TO INFORM THIS PRACTICE AND THE PROVIDER SO THAT ANY UPDATES OR CHANGES MAY BE REFELECTED AND A NEW SIGNATURE MUST BE OBTAINED AT THAT TIME.

Signature _____ **Date** _____

## Primary Insurance Information

## Patient Information

**Primary Dental Insurance:**

**Do you have Dental Insurance? *** ◯ Yes ◯ No

**If, NO, Please indicate how you are paying for treatment today:**

◯ Cash ◯ Credit/Debit ◯ Check ◯ Other:_____

**Name of Insured:** _____* _____* ____
Last First MI

**Insured's Birth Date:*** _____ **ID #:*** _____ **Group #:** _____

**Insured's Address:** _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

**Insured's Employer Name:*** _____

**Employer Address:** _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

**Patient's relationship to insured:*** ◯ Self ◯ Spouse ◯ Child ◯ Other

**Insurance Plan Name:*** _____

**Insurance Address:** _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

**Do you have a Secondary Dental Insurance Policy? *** ◯ Yes ◯ No

**Secondary Dental Insurance:**

**Name of Insured:** _____ _____ ____
Last First MI

**Insured's Birth Date:** _____ **ID #:** _____ **Group #:** _____

**Insured's Address:** _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

**Insured's Employer Name:** _____

**Employer Address:** _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

**Patient's relationship to insured:** ◯ Self ◯ Spouse ◯ Child ◯ Other

**Insurance Plan Name:** _____

**Insurance Address:** _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

## Consent for Services

I understand dentistry is not an exact science and success with periodontal treatment cannot be guaranteed. In view of the above information, I authorize the doctor and/or such associates and assistants as necessary to render any treatment necessary and/or advisable to my dental condition including any and all medications and anesthetics. I have provided as accurate and complete a medical and personal history as possible, including medical history , medical conditions, antibiotics or any other edications I am currently taking as well as those I am allergic. I will follow any and all treatment and post op treatment instructions as explained to me. I further understand that if no treatment is rendered, my present periodontal condition will probably worsen in time, which may result in premature tooth loss, but my condition could remain the same without the proposed treatment.

I also understand that a variety of surgical procedures are used to treat periodontal diseases and conditions. While these surgical procedures are generally successful, I understand that no guarantee, warranty, or assurance has been given me that the proposed treatment will be curative and/or successful to my complete satisfaction. A risk of failure, relapse, or worsening of my present condition may result despite treatment.

I CERTIFY THAT I HAVE FULLY READ AND UNDERSTAND THE ABOVE CONSENT TO THE SURGERY; THAT PROPOSED PROCEDURES, ALTERNATIVE TREATMENTS, AND RISKS OF SURGERY HAVE BEEN EXPLAINED. I ALSO STATE I SPEAK, READ AND WRITE ENGLISH (OR TRANSLATOR USED).

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

Signature of patient, parent, or guardian (responsible party):

Signature _____ **Date** _____

**Relationship to Patient:**

_____

_____

_____

**Response Date:** ____/____/_____