Periodontal Associates

Periodontics and Implants
9191 R.G.Skinner Parkway, Suite #404
Jacksonville, FL 32256
Phone (904) 731-4347 Fax (904) 737-4310

PATIENT QUESTIONNAIRE

Please Print: Date: _____

Name: _____ Social Security #: _____

Sex: _____ Date of Birth: _____ Age: _____ Marital Status: _____

Home Address: _____
Street Town/City/State Zip Code

Home Phone # _____ Business Phone # _____

Cell Phone # _____ Digital Pager # _____ E-mail: _____

Occupation: _____ Name of Employer: _____

Business/School Address: _____
Street Town/City/State Zip Code

Dental Insurance: _____

Subscriber Name: _____ Social Security # _____ Policy # _____

Send Claims To: _____ Phone # _____

Medical Insurance: _____

Subscriber Name: _____ Social Security # _____ Policy # _____

Send Claims To: _____ Phone # _____

Dentist: _____ Phone # _____

Address: _____
Street Town/City/State Zip Code

Physician: _____ Phone # _____

Address: _____
Street Town/City/State Zip Code

Referred by whom: _____ Phone # _____

Address: _____
Street Town/City/State Zip Code

Reason For Visit: _____

If a Student or Minor, Please Include: _____

Parent's Name: _____

Address: _____
Street Town/City/State Zip Code

Home Phone # _____ Business Phone # _____

Preferred Day(s) and Hour(s) For Appointments _____

I authorize Release Of Any Information Relating To Insurance.

I Hereby Authorize Payment Directly To M. A. Maksoud, DMD, PA Of The Group Insurance Benefits.

_____
Signed (Patient, or Parent If Minor) Date

_____
Signed (Insured Person) Date

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Please answer the following 3 questions by filling in the blanks. If you need help, ask the receptionist.

1. Chief complaint:
   What is or are your reasons for being here?

2. History of chief complaint:

3. Last dental visit and reason for visit:

1. _____
2. _____
3. _____

4. Past dental history (check all previous services received in dental facilities):

- ❒ Dental exam with x-rays
- ❒ Tooth extraction or oral surgery
- ❒ Restorations (fillings)
- ❒ Partial dentures (removable)
- ❒ Crown and bridgework (fixed)
- ❒ **Last dental cleaning** _____
- ❒ Complete dentures (plates)
- ❒ Periodontal treatment (gum treatment)
- ❒ Endodontic treatment (root canal treatment)
- ❒ Orthodontic treatment (braces)

5. Previous dental experiences

- ❒ Unpleasant experience with dentist(s) in past (describe) _____
- ❒ Pleased with previous dental experience

6. Self analysis of oral tissue health (check any problems that you have)

- ❒ Bad teeth (cavities)
- ❒ Crooked teeth
- ❒ "Dry Mouth" (not enough saliva)
- ❒ Bad bite; bite feels off
- ❒ Frequent sores in mouth or on lips
- ❒ Teeth painful to hot, cold, sweets (underline which)
- ❒ Bleeding gums
- ❒ Swelling in mouth or jaws on occasion (underline which)
- ❒ Loose or drifting teeth
- ❒ Food catching between teeth
- ❒ Bad taste in mouth
- ❒ Severe toothaches
- ❒ Other problems (describe) _____

7. Attitudes about dentistry

Y	N	
❒	❒	Most people will eventually lose their teeth.
❒	❒	Good dental care can prevent tooth loss.
❒	❒	Do you only see the dentist for emergency care?
❒	❒	Do you brush every day?
❒	❒	Do you floss every day?

8. Oral Habits

❒	❒	Do you or have you ever smoked cigarettes?	Frequency: _____ packs per day	_____ years
❒	❒	Do you chew tobacco or use snuff?	Frequency: _____ times per day	_____ years
❒	❒	Do you drink alcohol?	Frequency: _____ times per day	
❒	❒	Do you chew gum?	Frequency: _____ sticks per day	❒ sugar-free
❒	❒	Do you drink sugary drinks frequently?	Frequency: _____ times per day	

HEALTH HISTORY
REVIEW OF SYSTEMS

Please do not write in spaces below

		YES	NO	
CARDIOVASCULAR	1.	☐	☐	Have you ever been told you have heart trouble?
	2.	☐	☐	Have you ever been told you have ☐ high or ☐ low blood pressure?
	3.	☐	☐	Do you get out of breath easily?
	4.	☐	☐	Have you had rheumatic fever?
	5.	☐	☐	Do you have a heart murmur as a consequence of rheumatic fever?
	6.	☐	☐	Do you have a prolapsed mitral valve?
	7.	☐	☐	Have you ever been told that you have a heart murmur of any cause?
	8.	☐	☐	Have you ever been told to take antibiotics before dental treatment?
	9.	☐	☐	Have you had a heart attack?
	10.	☐	☐	Have you had a stroke?
	11.	☐	☐	Do your ankles become easily swollen?
	12.	☐	☐	Do you suffer from angina pectoris (chest and left arm pain)?
	13.	☐	☐	Have you ever taken the weight reduction drug Fen-phen?
SENSES	1.	☐	☐	Have you had earaches or other ear problems?
	2.	☐	☐	Have you had eye problems such as glaucoma or other problems?
	3.	☐	☐	Have you noticed any changes in your sense of taste or smell?
	4.	☐	☐	Do you have bad breath (halitosis)?
RESPIRATORY	1.	☐	☐	Do you have the flu or a cold more than twice a year?
	2.	☐	☐	Do you have asthma, hayfever, sinusitis, or frequent sore throats?
	3.	☐	☐	Have you had pneumonia or a lung infection?
	4.	☐	☐	Do you have, or have you been exposed to, tuberculosis?
	5.	☐	☐	Do you have a chronic cough or cough up blood?
	6.	☐	☐	Do you have bronchitis or emphysema?
NEUROLOGIC	1.	☐	☐	Have you ever been under psychiatric care or had counseling?
	2.	☐	☐	Do you have numbness or tingling feelings anywhere?
	3.	☐	☐	Have you ever had a nervous breakdown?
	4.	☐	☐	Are you anxious or depressed frequently?
	5.	☐	☐	Do you have epilepsy, seizures, or other neurologic disorders?
ENDOCRINE	1.	☐	☐	Do you have diabetes?
	2.	☐	☐	Does any member of your family have diabetes?
	3.	☐	☐	Are you thirsty frequently or urinate frequently?
	4.	☐	☐	Do you have thyroid problems or take thyroid tablets?
	5.	☐	☐	Do you have any other gland problems?
G-I	1.	☐	☐	Have you had jaundice, liver trouble or hepatitis?
	2.	☐	☐	Do you have stomach problems or ulcers?
	3.	☐	☐	Do you have frequent or prolonged diarrhea or constipation?
	4.	☐	☐	Do you have frequent episodes of acid reflux or vomiting?
	5.	☐	☐	Has your weight changed more than 20 pounds in the past year?
G-U	1.	☐	☐	Have you ever been told that you have kidney or bladder trouble?
	2.	☐	☐	Have you had any sexually transmitted diseases (syphilis, gonorrhea, genital herpes, HIV infection, AIDS)?
	3.	☐	☐	Have you had any reproductive tract problems?
HEMATOLOGY	1.	☐	☐	Have you had anemia?
	2.	☐	☐	Do you have leukemia?
	3.	☐	☐	Do you bruise or bleed easily?

	YES	NO		
1.	☐	☐	Are you sensitive or allergic to any medications? (penicillin, sulfa drugs, aspirin, etc.)	IMMUNOLOGY
2.	☐	☐	Are you allergic to any foods, metals, pollens or latex (rubber)?	
3.	☐	☐	Have you been treated for a skin disease?	
4.	☐	☐	Do you have a defective immune system?	
5.	☐	☐	Do you take medications that suppress your immune system?	

1.	☐	☐	Are your joints often painfully swollen or do you have arthritis?	MUSC-SKEL
2.	☐	☐	Do you have back problems?	
3.	☐	☐	Have you had more than one fracture or dislocation?	
4.	☐	☐	Do you have osteoporosis?	

1.	☐	☐	Have you had an operation?	SURGERY-ANESTHESIA
2.	☐	☐	Have you had a series of shots or injections?	
3.	☐	☐	Have you ever had anesthesia? ☐ Local ☐ General	
4.	☐	☐	Have you ever been told not to take novocaine or any other medication?	
5.	☐	☐	Have you ever been told you had cancer or a tumor?	
6.	☐	☐	Have you ever had chemotherapy?	
7.	☐	☐	Have you ever had radiation therapy?	
8.	☐	☐	Have you ever had an organ or bone marrow transplant?	
9.	☐	☐	Are you using any recreational drugs or substances?	
10.	☐	☐	Are you an active or recovering substance abuser?	

1.	☐	☐	Do you have a prosthetic (artificial) heart valve?	IMPLANTS
2.	☐	☐	Do you have a pacemaker or defibrillator?	
3.	☐	☐	Have you had vascular or cardiac repair with synthetic materials?	
4.	☐	☐	Do you have a vascular shunt (hemodialysis or drug therapy)?	
5.	☐	☐	Do you have any prosthetic joints (hip, knee, ankle, shoulder)?	
6.	☐	☐	Do you have any other implant?	

1.	☐	☐	Do you have a history of head or neck injury?	FACIAL PAIN
2.	☐	☐	Have you ever had severe pains of the face or head?	
3.	☐	☐	Do you suffer from headache, eye pain or migraine?	
4.	☐	☐	Do you have ear pain or pain in front of your ears?	
5.	☐	☐	Does anything hurt when you chew?	
6.	☐	☐	Does your jaw make noise that bothers you or others?	
7.	☐	☐	Does the pain or discomfort interfere with your work activities?	

For Women only:				WOMEN
1.	☐	☐	Are you taking birth control pills or have Norplant?	
2.	☐	☐	Are you pregnant? Expected delivery date: _____	
3.	☐	☐	Are you breast feeding?	

HOSPITALIZATIONS OR OUTPATIENT PROCEDURES	Year	City	Procedure	Complications

Overall Health _____

When was the last physical exam by a Physician? _____

Any additional information? _____

Please do not write in spaces below

Medications

DATE	DRUG NAME	DRUG CLASSIFICATION	PRESCRIBED FOR	CONTRAINDICATIONS OR INTERACTIONS
☐ CURRENT ☐ DISCONT'D	BRAND: GENERIC:			
☐ CURRENT ☐ DISCONT'D	BRAND: GENERIC:			
☐ CURRENT ☐ DISCONT'D	BRAND: GENERIC:			
☐ CURRENT ☐ DISCONT'D	BRAND: GENERIC:			
☐ CURRENT ☐ DISCONT'D	BRAND: GENERIC:			
☐ CURRENT ☐ DISCONT'D	BRAND: GENERIC:			

I verify that to the best of my knowledge, the above health history is correct._____

Patient Signature Date

_____

Doctor's Signature Date

1. List Drugs You Are Presently Taking

_____

2. Pharmacy Name . . . . . _____

3. Pharmacy Phone. . . . . _____

4. In Case Of Emergency, Notify: . . . _____

5. Phone . . . . . _____

_____

Patient Signature Date

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AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient's name:_____ **Date of birth:**_____

SSN:_____ **Previous name:**_____

Doctor's name:_____

Practice name:_____

I request and authorize the above listed doctor and practice to release health care information of the patient named above to:

Name:_____

Address:_____

City, State:_____ **Zip Code:**_____

This request and authorization applies to health care information relating to the following treatment, condition, or dates of treatment:

_____

or_____ **All health care information**
or_____**Other:**_____

THIS AUTHORIZATION EXPIRES ON_____**or** _____**DAYS AFTER**

THE DATE IT IS SIGNED or WHEN THE FOLLOWING EVENT OCCURS_____

_____

I may cancel this authorization to the extent allowed by law. If I do, I understand that the doctor or practice may have already released information about me after I gave permission. I know that canceling this authorization would not prohibit any release of information by the doctor or practice in reliance on my original authorization.

There are two ways to cancel this agreement. I can:
Sign and date a form available from the doctor or practice called "Revocation of Authorization for Use and Disclosure of Health Care Information" or

Write a letter to the doctor or practice. If I write a letter, it must say that I want to cancel my authorization to disclose my health care information. I (or my authorized representative) must sign and date the letter.

Once my doctor gives out the information that I want released, I know that my doctor has no control over the information. The individual or organization that I authorized to receive the information might re-disclose it. Federal or state privacy laws may no longer protect the information.

_____
Signature of patient or patient's authorized representative **Date signed**

_____
Relationship or status if signed by parent, legal guardian, personal representative, etc.

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Financial Responsibility

- **As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor, in other words you agree to have your insurance pay the doctor directly.**
- **If your insurance company does not pay the practice within a reasonable length of time, (within 45 days) you may be responsible.**
- **Your insurance policy is a contract between you and your insurance company; the doctor is not involved.**
- **We have made prior arrangements with many insurers and other dental plans to accept an assignment of benefits. We will bill those plans for which we have an agreement and will only require you to pay the authorized co-payment at the time of service. We will collect the co-payment at the time of the service.**
- **If you fail to notify us of an insurance change, you are fully responsible for any amount not paid by your insurance company.**
- **Full payment is due at the time of service. For your convenience we will accept all major credit cards.**
- **All dental plans are not the same and do not cover the same services. In the event your dental plan determines a service to be "not covered", you will be responsible for the complete charge.**
- **In order to provide the best possible service and availability to all our patients please call us as early as possible if you know you need to reschedule your appointment. There is a late cancellation fee if you do not cancel or reschedule your appointment within 72 hours.**

I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

I hereby state that I have listed ALL the DENTAL INSURANCE COVERAGE that I currently have, and am aware of no other insurance(s). Otherwise, I am responsible for any claims not paid because of not informing this clinic of all coverages.

Signature of Party who filled out the registration forms and is responsible for this agreement

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Todays Date
