Setter Periodontics and Implant Dentistry

Patient's Name: _____ Preferred Name: _____ Date: _____

Address: _____ City/State:_____ Zip:_____

Home Phone: _____ Work: _____ Cell: _____ Which is best to call? _____

Birthdate: _____ Marital Status: _____ SSN: _____ E-Mail: _____

Employer: _____ Current Dentist: _____

Reason for Visit: _____

Whom can we thank for referring you? _____

Date of Last Dental Visit: _____ Date of Last Cleaning: _____

Are you happy with the appearance of your smile? _____

What would you change about your smile or bite if you could? _____

Would you be interested in learning how your smile may be enhanced? _____

What are your long-term goals for oral health? _____

What is your biggest concern about having dental treatment? How can we make you most comfortable?

_____

How often do you brush your teeth? _____ Floss? _____

Are you having any pain right now?	YES	NO
Do your gums bleed while brushing or flossing?	YES	NO
Have you ever been treated for periodontal (gum) disease?	YES	NO
Have your relatives lost their teeth or had gum disease?	YES	NO
Do you have sore or painful teeth?	YES	NO
Have you noticed any loose teeth or changes in your bite?	YES	NO
Do you have lost or broken fillings?	YES	NO
Have you had orthodontic treatment (braces)?	YES	NO
Do you have a dry mouth?	YES	NO
Do you have any swelling or lumps in your mouth?	YES	NO
Do you clench or grind your teeth?	YES	NO
Do you have clicking, popping, or pain in your jaw?	YES	NO
Are you nervous about dental treatment?	YES	NO
Do you require pre-medication?	YES	NO
If yes, what medication? _____		
Have you had previous complications from dental treatment?	YES	NO
If yes, please explain: _____		

Setter Periodontics and Implant Dentistry – Health History

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

Heart Disease	Yes No	Diabetes	Yes No
Heart Attack	Yes No	Kidney Disease/Dialysis	Yes No
Heart Murmur or		Liver Problems	Yes No
Mitral Valve Prolapse	Yes No	Thyroid Problems	Yes No
Rheumatic Fever	Yes No	Epilepsy	Yes No
Pacemaker	Yes No	Fainting/Seizures	Yes No
Angina/Chest Pains	Yes No	Arthritis	Yes No
High Blood Pressure	Yes No	Osteoporosis	Yes No
Low Blood Pressure	Yes No	Respiratory Problems	Yes No
Stroke	Yes No	Cancer	Yes No
Blood Transfusions	Yes No	Radiation/Chemo Therapy	Yes No
Anemia	Yes No	Psychiatric Care	Yes No
Bleeding Disorders	Yes No	Drug/Alcohol Abuse	Yes No
Hip/Joint Replacement	Yes No	Frequent Headaches	Yes No

Are you in general good health? Yes No

Any other medical condition not listed? _____

Do you have or have you been exposed to:

Tuberculosis	Yes No	HIV/AIDS	Yes No
Hepatitis (any type)	Yes No	Herpes/ Cold sores	Yes No

Have you been under a physician's care within the last 2 years? Yes No

If yes, explain _____

Name/Date of Last Physician Visit _____

Do you smoke tobacco or use tobacco products? Yes No How much? _____

Are you taking ANY blood thinners? Yes No Please list_____

Are you allergic to or had a reaction to any of the following:

Penicillin	Yes No	Erythromycin	Yes No
Codeine	Yes No	Sulfa Drugs	Yes No
Aspirin	Yes No	Latex	Yes No

Other_____

Have you had any complications from dental anesthetics? Yes No

Please list all prescription and non-prescription drugs you are using: _____

_____

Please list all herbal supplements/remedies you are taking: _____

_____

Women please check any that apply: Pregnant or Nursing? Yes No

Taking Birth Control Pills? Yes No

Hormone Replacement Therapy Yes No

The information given above is correct to the best of my knowledge. I understand this information is held in strict confidence and it is my responsibility to inform this office of changes in my health status.

Signature: _____ Date: _____

Acknowledgement and Release

To the best of my knowledge, the above information is correct and I am responsible to inform the office of any changes. I understand that my health information will remain confidential and the Notice of Privacy Practices and Appointment Policy have been made available to me. I may request a copy of these Notices at any time, as it is subject to change in accordance with the law.

I consent to the taking of photographs and x-rays before, during, and after treatment by Dr. Setter for use in scientific and/or academic presentations.

Insurance: We provide services for our patients with the understanding that they are responsible for payment in accordance with our financial policy. We will prepare and submit forms and reports to assist you in obtaining maximum benefits available, but in no case are treatment recommendations or fees affected by the presence or absence of insurance benefits. Treatment recommendations are based on your dental needs and desires and are not a reflection of your dental benefits. Dr. Setter will not compromise the care that they provide because of inadequate insurance benefits. Your dental benefits are a contract between you, your employer, and the insurance company. We are not providers, members or have any association with any insurance organizations. I authorize the release of any pertinent information to the insurance company that is necessary to process my claims and I authorize my insurance benefits to be paid directly to the dentist if assignment of benefits is allowed.

Collections: In the event the balance becomes more than 30 days overdue, the balance may be subject to additional finance charges. If the balance becomes more than 60 days overdue, billing may be turned over to an outside collection agency. The responsible party listed above agrees to pay interest, collection and other legal expenses related to collection of fees owed. Waiver of any breach of any time or condition shall not constitute a waiver of any further term or condition.

Signature of patient or guardian: _____ Date: _____

Account and Dental Benefit Information

As a courtesy to our patients, our office accepts assignment of dental benefits and will coordinate with your benefit plan as needed on your behalf. However, please note that the full payment is the sole responsibility of the patient. If you would like us to file claims for your treatment in our office with your dental benefit plan, please fill out the information below.

Benefits Through Your Employer

Subscriber's Name: _____ ID or SS#: _____ Birthdate: _____

Employer: _____

Insurance Co. Name: _____ Claims Address: _____

Insurance Co. Phone: _____ Group #: _____

Benefits Through Another Person's Employer

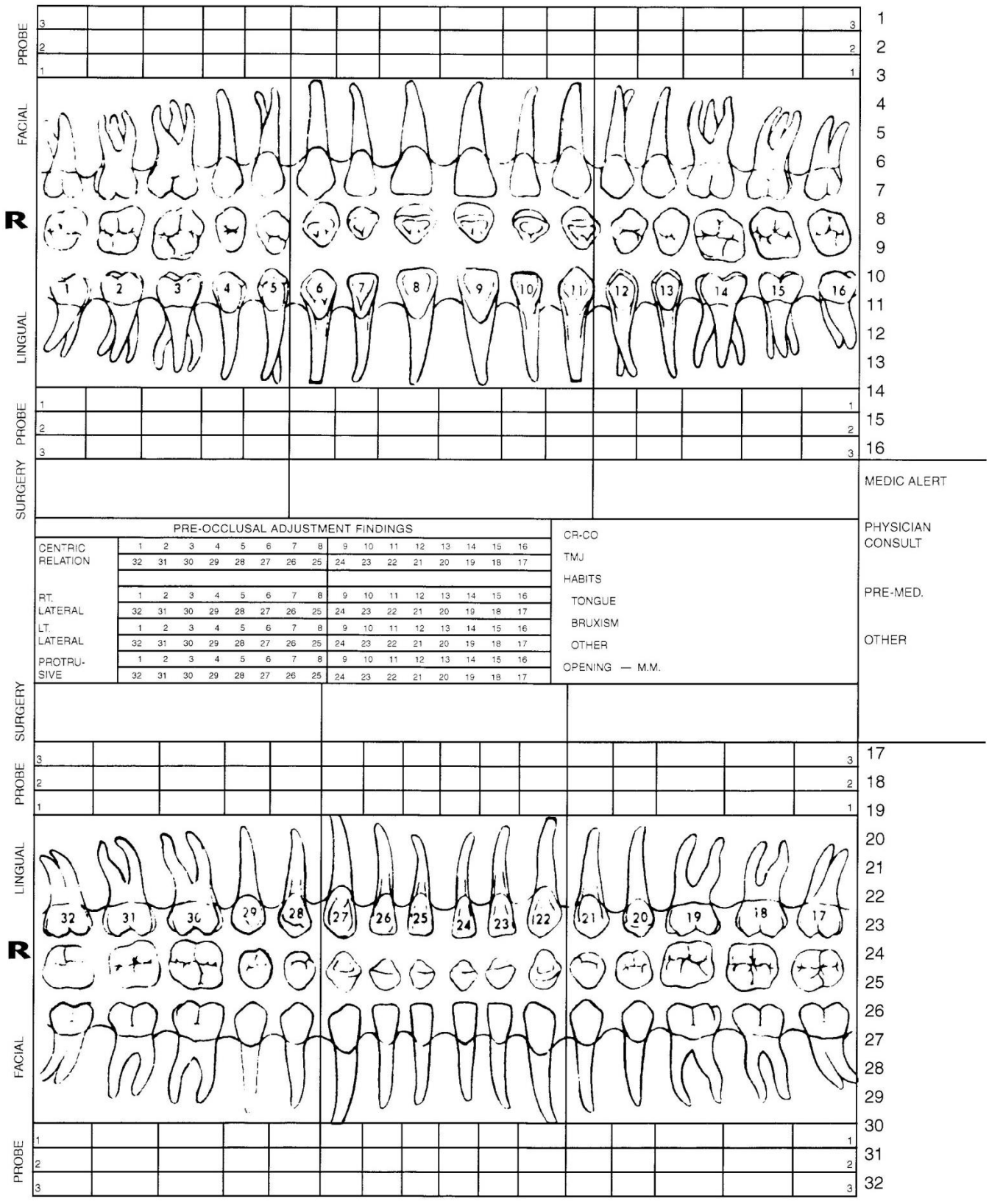
Subscriber's Name: _____ ID or SS#: _____ Birthdate: _____

Employer: _____ Relationship to Patient: _____

Address if different: _____

Insurance Co. Name: _____ Claims Address: _____

Insurance Co. Phone: _____ Group #: _____



NAME _____ DATE _____ DATE _____ DATE _____