Northwest Implants & Periodontics

PATIENT REGISTRATION

TODAY'S DATE: _____ E-mail: _____

PATIENT INFORMATION

Name	Preferred Name		Birth Date	Social Security #
Street Address	City	State	Zip	Home Phone
Employer				Work Phone
Occupation	Sex: M F	Marital Status:		Cell Phone

SPOUSE INFORMATION

Name		Birth Date	Social Security #
Employer	Cell Phone		Work Phone

IF PATIENT IS A MINOR, PLEASE COMPLETE THE FOLLOWING:

Name of personal responsible for bill:			Birth Date	Social Security #
Street Address	City	State	Zip	Home Phone
Employer				Work Phone
Occupation	Relationship to Patient			Emergency Phone

GENERAL INFORMATION

Your Dentist Name	Phone	City	How Long
Your Physician Name	Phone	City	How Long
Emergency Contact	Phone		Relation

DENTAL INSURANCE INFORMATION

Primary Coverage – Name of Insurance Company		Secondary Coverage – Name of Insurance Company	
Name of Policy Holder	Birth Date	Name of Policy Holder	Birth Date
Policy/Group #	Subscriber #	Policy/Group #	Subscriber #
Mailing Address	Phone #	Mailing address	Phone #

ASSIGNMENTS:

I authorize payment directly to Dr. Friedman for benefits he is entitled to under my dental/medical insurance plans. I authorize Dr. Friedman to obtain information regarding my credit history. I understand I am responsible for any unpaid balance on my account and failed appointments are subject to charges.

Patient's Signature	If Patient is a Minor, Signature of Parent or Guardian

TURN OVER ▸

MEDICAL HISTORY

Although some of the following questions may seem unrelated to your teeth, they are associated with proper management of your oral health and are confidential.

List any drug allergies: _____ Latex Allergy? □ Yes □ No

List any medications you are currently taking or have taken in the past year:

Prescribed: _____

Over-the-counter: _____

Herbal: _____

Please check any that apply:

□ If all answers below are 'no' please check here

□ Hepatitis	□ Heart Trouble	□ Excessively swollen ankles	□ Sleep apnea
□ Jaundice	□ Heart Murmur	□ Kidney Disease	□ Shortness of breath
□ Epilepsy	□ Stroke	□ Fibromyalgia	□ Hives, skin rash, hay fever
□ Arthritis	□ Chest pains	□ Stomach or Duodenal Ulcer	□ Asthma
□ Rheumatic Fever	□ High blood pressure	□ Liver Disease	□ Psychiatric treatment
□ Scarlet Fever	□ Low blood pressure	□ Tuberculosis	□ HIV or AIDS
□ Anemia or Blood Disorders	□ Prolonged Bleeding	□ A tumor or abnormal growth	□ Thyroid or parathyroid disorder
□ Diabetes	□ Radiation treatment	□ Emphysema □ Glaucoma	□ Prostate disorders

Are you:

- □ Presently being treated for any illness or disease?
- □ Taking Aspirin each day? If so, how many mg? _____
- □ Aware of a change in your general health in the past year?
- □ Aware of any recent weight change?
- □ Often thirsty?
- □ Urinating more than six times per day?
- □ Often exhausted and fatigued?
- □ Subject to frequent headaches?
- □ Do you use tobacco in any form? Type: _____

If you are female, Are you:

- □ Pregnant or breast feeding?
- □ Taking birth control or other hormones?
- □ Experiencing Menopause
- □ Post menopausal

Please fully explain anything checked above: _____

_____

Have you been hospitalized for any illness or surgery? _____

_____

DENTAL HISTORY (Please give a brief explanation)

- What is your estimate of your dental health? GOOD FAIR POOR
- Do you presently have any dental pain or problems? _____
- Do your gums bleed? Y N Where? _____ When? _____
- Do you have sensitive teeth? _____
- Does food wedge between your teeth? _____
- Do you chew satisfactorily? _____
- Have you neglected regular dental care in the past? _____
- Do you clench or grind your teeth during the day or night? _____
- Have you experienced prolonged bleeding or slow healing after a tooth extraction? Y N Explain
- Have you ever been treated for periodontal disease (pyorrhea) Y N Details: _____
- Have you ever had orthodontic treatment? Y N Details: _____
- How would you feel if you lost your teeth? _____
- Other comments on your mouth or dental history: _____

STATEMENT OF ACKNOWLEDGEMENT

Periodontal disease is caused by a combination of factors. Periodontal treatment is prescribed to control specific causative factors present in each particular case.

The success of periodontal therapy and dental treatment in general, is dependent on many factors including the severity of the periodontal destruction, the patient's general physical status, and the patient's ability and willingness to perform proper oral hygiene on a regular basis. As with treatment of any condition, especially where drugs and surgical procedures are being used, unsuspected problems can arise. Such problems can include hemorrhage, prolonged or permanent numbness in a treated area, sensitivity to medications and incomplete healing, gum recession, margin exposure, and food impaction. Also, other problems such as loose teeth, sensitivity to hot and cold, pulp damage, and tooth loss can be encountered.

We will make every effort to keep you informed of the treatment outlined for you. Your involvement and understanding are very important in the long term success of your periodontal therapy. PLEASE INFORM THE DOCTOR IF YOUR HEALTH CHANGES IN ANY WAY.

PATIENTS SIGNATURE: _____ DATE: _____

REVIEWED BY: _____ DATE: _____