Ross E. Kline, DMD
Michael Vener, DMD

periodontalassociates.com

Practice Specializing in Periodontics & Implant Dentistry

Patient Registration

Please print answers

Patient Name

Preferred Name

Address

City/State/Zip

Marital Status: ☐ Single ☐ Married
☐ Separated ☐ Divorced ☐ Widow

Gender: ☐ Male ☐ Female

Pref Pronoun: ☐ He/Him ☐ She/Her ☐ They/Them

Birthday | Social Security #

Contact Information

Home | Work | Cell

E-mail

Employer

Occupation

Guarantor/Responsible Party

(If other than patient)

Guarantor Name

Address

City/State/Zip

Phone Number

Birthday

Emergency Contact

This is not a HIPAA authorization

Name

Phone Number

Relationship to Patient

Primary Dental Insurance

Insurance Carrier Name

Identification Number | Group Number

Group Name

Ins. Phone #

Subscriber Name (if different than patient)

Subscriber Birthday

Secondary Dental Insurance

Insurance Carrier Name

Identification Number | Group Number

Group Name

Ins. Phone #

Subscriber Name (if different than patient)

Subscriber Birthday

Ross Kline, DMD
Michael Vener, DMD

Medical History Form

Today's Date: ____________

Last Name: ____________________ First Name: ____________________ Patient DOB: ____________

Periodontal disease is caused by a combination of complex factors and the following questions are designed to help us identify them. The success of therapy is dependent upon this. Although some of the following questions may seem unrelated to your personal condition, they are all associated with proper management of your oral condition and are held in strict confidence in compliance with the Health Insurance Portability and Accountability Act (HIPAA).

Medical History

Name of Medical Doctor: ______________________________ City/State: ______________________

Phone Number: ______________________________ Date of last physical exam: ____________

Y N Are you presently under a physician's care? If yes, for what? ______________________________

Y N Have you ever been hospitalized? If yes, for what? ______________________________

Y N Has there been any change in your health in the past year?

Y N Have you ever been advised to pre-medicate with antibiotics for dental appointments?

Y N Are you currently required to pre-medicate with antibiotics for your dental appointments?

Y N Do you currently smoke or vape? If yes, for how long? ____________________

Y N Do you use any other form of tobacco or nicotine product? If yes, what kind? ____________________

Y N Have you ever used tobacco or nicotine products? If yes, when did you quit? ____________________

Y N Do you use medically prescribed marijuana? If yes, by what method? ____________________

Are you allergic to or react adversely to any of the following?

Y	N		Y	N	
☐	☐	Anesthetic (Novacaine)	☐	☐	Ibuprofen (Motrin)
☐	☐	Aspirin	☐	☐	Latex
☐	☐	Barbituates, sedatives, sleeping pills	☐	☐	Penicillin
☐	☐	Codeine or other narcotics	☐	☐	Other ____________________

Do you have any, or have you had of the following medical conditions? Please check YES or NO.

Y	N		Y	N	
☐	☐	Asthma, allergies, or respiratory problems	☐	☐	Heart trouble or stroke
☐	☐	Arthritis, rheumatism	☐	☐	HIV/AIDS positive
☐	☐	Abormal bleeding problems or blood disorder	☐	☐	High or Low Blood Pressure
☐	☐	Chest pain, ankle swelling, shortness of breath	☐	☐	Pacemaker
☐	☐	Cardiac valve prosthesis	☐	☐	Prosthetic Joints (Hips/Knees/Etc.)
☐	☐	Diabetes	☐	☐	Stomach or duodenal ulcers
☐	☐	Epilepsy or Seizures	☐	☐	Radiation Treatments
☐	☐	Glaucoma	☐	☐	Sinus Surgery
☐	☐	Heart murmur/Mitral valve prolapse	☐	☐	Tuberculosis
☐	☐	Hepatitis, jaundice or liver disease	☐	☐	Any other medical conditions? ____________

Women

Y	N		Y	N	
☐	☐	Are you pregnant?	☐	☐	Do you take birth control medication?
☐	☐	Are you post-menopause?	☐	☐	Do you take hormonal supplements or medications?

Continued on next page

Dental History

Please circle Yes or No for the following questions.

Y N Are you in pain now?

Y N Have you ever been treated for periodontal disease?

Y N Do your gums bleed while brushing or flossing?

Y N Do your teeth feel loose?

Y N Do you grind or clench your teeth or jaw during the day or night?

Y N Do you have sore or senstive teeth?

Y N Do you have pain elsewhere in your face or jaw?

Y N Have you ever had your teeth straightened? (Orthodontics) If yes, when? ______________________

Y N Do you use dental floss, toothpicks, or other water irrigation devices? If yes, how often? ______________

Y N Do you wear dentures?

Y N Do you have sleep apnea? If yes, do you wear a CPAP at night? ______________________

How long have you known about your gum condition? ______________________

How often do you brush your teeth? ______________________

How often do you have your teeth professionally cleaned? ______________________

General Dentist Information

Dr. or Practice Name ______________________

Phone # ______________________

Medications

Are you currently taking any of the following medications? Check yes or no.

Y	N		Y	N	
☐	☐	Antibiotics	☐	☐	Cortisone (steroids)
☐	☐	Anticoagulants (Blood thinners)	☐	☐	Heart Medication: ______________
☐	☐	Aspirin	☐	☐	Nitroglycerin
☐	☐	High Blood Pressure Medication	☐	☐	Tranquilizers
☐	☐	Diabetes Medications: ______________			
☐	☐	Bone Density medication: ______________ (like Boniva, Fosamax, Actonel or Reclast)			

Other medications: ______________________

Pharmacy Info

Pharmacy Name: ______________________ Phone Number: ______________________

Address: ______________________

I certify that the information above is true and accurate to the best of my knowledge, as of the date below.

Patient Signature: ______________________ Date: ______________

Doctor Signature: ______________________ Date: ______________

Ross Kline, DMD
Michael Vener, DMD

periodontalassociates.com

Practice Specializing in Periodontics & Implant Dentistry

Acknowledgement of Receipt of Privacy Policies

Last Name: ___________________ First Name: ___________________ Birthdate: ___________________

______ Initials — I hereby acknowledge that I have received or have been given the opportunity to receive a copy of Periodontal Associates' Notice of Privacy Practices. By signing below I understand that I am giving my permission to your use and disclosure of my protected health information in order to carry out treatment, payment activities, and healthcare operations. I also understand that I have the right to revoke permission.

OPTIONAL:

______ Initials — I authorize the following person(s) to discuss my account, including but not limited to, balances, appointment dates and times, scheduled procedures and communications with Periodontal Associates:

____

____

____

Consent to Treatment

______ Initials — I hereby give my permission to Periodontal Associates for the evaluation and treatment of my dental condition. I am requesting that periodontal services be provided to me (or the patient named above) at Periodontal Associates. These services may include but are not limited to: diagnostic, therapeutic, imaging, and laboratory services. I am aware that the practice of medicine and dental health are not an exact science; no guarantees have been made to me about the results of treatments, examinations, or services.

Consent to Imaging

______ Initials — I understand that Periodonal Associates requires the use of diagnostic imaging, x-rays, and/or photographs to provide a complete assessment of each patient's mouth. The diagnostic imaging may be used for: Identification purposes, insurance records, medical research, and/or preparation for treatment.

The practice occasionally uses these images for educational purposes, or promotional materials that include x-rays, or before and after photographs. At no time will my private information or any identifiable characteristics be shared publicly.
(Check one option below.)

_____ OK to use imaging for educational and/or promotional material.

_____ Please refrain from using imaging, except for diagnostic and treatment purposes.

Signature: ______________________________ Date: ____________________

PERIODONTAL
ASSOCIATES

Ross Kline, DMD
Michael Vener, DMD

periodontalassociates.com

Practice Specializing in Periodontics & Implant Dentistry

Office Financial Policy

Last Name: ____________ First Name: ____________ Birthdate: ____________

Late and Missed Appointment Agreement

*Periodontal Associates believes in respecting the time of our patients, and makes every effort to ensure timely appointment keeping. In the same regard, our practice requests that if you are going to be more than 5 minutes late to your appointment, promptly notify the office. After 10 minutes past your appointed time, the appointment is considered forfeited and may be recorded as a broken appointment.

*We require a minimum of 2 business days' notice of cancellation for all exams, surgical and maintenance procedures. If this notice is not received, the practice reserves the right to charge for missed or broken appointments. We understand difficult situations arise that are out of your control, and will consider waiving the first cancellation fee as a courtesy.

*Charges for missed appointments are as follows:

- Hygiene visits/Periodontal Maintenence: $50.00
- Doctor exams, including consults: $50.00
- Scaling/Root Planing: $75.00 per quadrant
- Surgical visit: $100.00 per scheduled hour

Billing Agreement

Payment is due at the time of the appointment for all procedures, whether the patient is insured or uninsured. Failure to pay balances may result in several attempts to collect the balance by Periodontal Associates. If we are unsuccessful in these attempts, the account may be forwarded to our collection agency for processing. If the account proceeds to collections, no future appointments can be made and the practice reserves the right to cancel any future scheduled appointments.

Insured Patients

For my convenience, this office may release my information to my insurance company, in order to recieve reimbursement.

*I understand that all estimated co-pays will be due at the time of service and insurance will be billed on my behalf.

*I understand that any estimates prepared are not finalized co-payments for procedures. Final determination will be made by my insurance carrier once claims are processed and paid. A bill may be due after this process is complete.

Periodontal Associates accepts no responsibility for those who choose not to read or agree to the policy; the policy will still apply.

I have read and agree to the above policies regarding Periodontal Associates' billing procedures.

______________________________ Patient Signature

______________________________ Date