PRESCOTT PERIODONTICS & IMPLANT DENTISTRY, PLLC

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Name: ____
Last First Middle Initial Preferred Name

Birth Date: ____________ SSN: ______ - ____ - ______ ☐ Male ☐ Female

Address: ____
Street City State Zip Code

Phone: ____________ ____________ ____________
Home Cell Work

Email Address: ____

Employer: ____________ Occupation: ____________ ☐Retired

Emergency Contact: ____
Name Relationship Phone Number

Preferred Method Of Contact For Appointment Confirmations: ☐Email ☐Text ☐Cell Phone ☐Home Phone

RESPONSIBLE BILLING ADDRESS (if different from patient, please check one)

☐ Parent ☐ Guardian ☐ Spouse

Name: ____
Last First Middle Initial

Address: ____
Street City State Zip Code

Phone: ____________ ____________ ____________
Home Cell Work

PRIMARY DENTAL BENEFIT PLAN

A copy of your insurance card is required.

Plan Name: ____________

Plan Address: ____________

City: ________ State: ____ Zip: ________

Plan Telephone: ____________

SUBCRIBER INFO:

Name of Subscriber: ____________

Policy Holder/Subscriber ID #: ____________

Group Number: ____________

Date of Birth: ____________

SSN: ______ - ____ - ______

Employer Name: ____________

Patient Relationship to Subscriber (please check one)

☐ Self ☐ Spouse ☐ Dependent ☐ Other

SECONDARY DENTAL BENEFIT PLAN

A copy of your insurance card is required.

Plan Name: ____________

Plan Address: ____________

City: ________ State: ____ Zip: ________

Plan Telephone: ____________

SUBCRIBER INFO:

Name of Subscriber: ____________

Policy Holder/Subscriber ID #: ____________

Group Number: ____________

Date of Birth: ____________

SSN: ______ - ____ - ______

Employer Name: ____________

Patient Relationship to Subscriber (please check one)

☐ Self ☐ Spouse ☐ Dependent ☐ Other

I authorize and request my dental benefit company to pay directly to Prescott Periodontics & Implant Dentistry, PLLC, all benefits, if any, otherwise payable to me. I understand that I am financially responsible for all charges whether or not paid by my benefit plan.

Prescott Periodontics & Implant Dentistry, PLLC will contact you by email and text message for appointment confirmations.

Signature of Patient: (or guardian) ____________________ **Date:** ____________

MEDICAL HISTORY

Name: ______________________________

Primary Care Physician: ______________________________

Date: ______________________________

Periodontists specialize in the prevention, diagnosis, and treatment of periodontal disease and the placement of dental implants. Health problems that you have or medications that you are taking have an important inter-relationship with the dental care you receive. Because your oral health affects your entire body, it is essential that we have a complete medical history. Thank you for answering the following questions.

Please rate your overall health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you take any of the following medications on a regular basis?

Aspirin	☐ YES	☐ NO	Pain Medications	☐ YES	☐ NO
Blood Thinners	☐ YES	☐ NO	Bisphosphates (Actonel, Boniva, Fosamax)	☐ YES	☐ NO

Do you have tuberculosis? ☐ YES ☐ NO

Are you pregnant? ☐ YES ☐ NO

Are you nursing an infant? ☐ YES ☐ NO

PLEASE INDICATE THOSE CONDITIONS THAT YOU HAVE OR HAVE HAD IN THE PAST:

Cardiovascular	**Yes**	**No**
Angina (Chest Pain)	☐	☐
Artificial Heart Valve	☐	☐
Congestive Heart Failure	☐	☐
Damaged Heart Valve	☐	☐
Heart Attack	☐	☐
Heart Disease	☐	☐
Heart Murmur	☐	☐
Heart Surgery	☐	☐
High Blood Pressure	☐	☐
High Cholesterol	☐	☐
Irregular Heart Beat	☐	☐
Mitral Valve Prolapse	☐	☐
Pacemaker	☐	☐
Rheumatic Fever	☐	☐
Stroke	☐	☐
Hematologic	**Yes**	**No**
Abnormal Bleeding	☐	☐
Anemia	☐	☐
Blood Transfusion	☐	☐
Bruise Easily	☐	☐
Hemophilia	☐	☐
Leukemia	☐	☐
Sickle Cell Anemia	☐	☐
Respiratory	**Yes**	**No**
Asthma	☐	☐
COPD	☐	☐
Difficulty Breathing	☐	☐
Emphysema / Bronchitis	☐	☐
Lung Disease	☐	☐
Sleep Apnea	☐	☐
Endocrine	**Yes**	**No**
Diabetes	☐	☐
Thyroid Disease	☐	☐
Renal	**Yes**	**No**
Kidney Disease	☐	☐
Dialysis	☐	☐

Immune	**Yes**	**No**
Immunosuppressive Disease	☐	☐
Past Use Of Steroids	☐	☐
Delayed Healing	☐	☐
Sjogren's Syndrome	☐	☐
Musculoskeletal	**Yes**	**No**
Arthritis	☐	☐
Artificial Joint	☐	☐
Back Problems	☐	☐
Chronic Fatigue Syndrome	☐	☐
Fibromyalgia	☐	☐
Lupus	☐	☐
Osteoporosis	☐	☐
Gastrointestinal	**Yes**	**No**
Acid Reflux / GERD	☐	☐
Chronic Diarrhea	☐	☐
Crohn's Disease	☐	☐
Irritable Bowel Syndrome	☐	☐
Stomach Ulcer	☐	☐
Hepatic	**Yes**	**No**
Hepatitis	☐	☐
Jaundice	☐	☐
Liver Disease	☐	☐
Neurologic	**Yes**	**No**
Alzheimer's Disease	☐	☐
Cerebral Palsy	☐	☐
Dementia	☐	☐
Epilepsy	☐	☐
Fainting / Dizziness	☐	☐
Headaches	☐	☐
Multiple Sclerosis	☐	☐
Parkinson's Disease	☐	☐
Seizures	☐	☐
Skin	**Yes**	**No**
Hives or Skin Rash	☐	☐
Skin Disorders	☐	☐

Eyes / Ears	**Yes**	**No**
Glaucoma	☐	☐
Impaired Hearing	☐	☐
Impaired Vision	☐	☐
Mental Health	**Yes**	**No**
Anxiety	☐	☐
Bipolar Disorder	☐	☐
Depression	☐	☐
Eating Disorder	☐	☐
Sleep Disorder	☐	☐
Infectious Diseases	**Yes**	**No**
Aids / HIV Positive	☐	☐
Sexually Transmitted Disease	☐	☐
Other	**Yes**	**No**
Cancer	☐	☐
Chemotherapy	☐	☐
Radiation Treatment	☐	☐
Alcohol Use	☐	☐
Chemical Dependency	☐	☐
Recreational Drug Use	☐	☐
Sinus Problems	☐	☐
Tobacco Use	☐	☐
Allergies	**Yes**	**No**
Latex	☐	☐
Penicillin	☐	☐
Codeine or other narcotics	☐	☐
Local Anesthetics	☐	☐
Sedatives	☐	☐

Allergies or other Medical Conditions:

____

____

____

____

MEDICATION INFORMATION

Name: ____________________

Date: ____________________

Medications

Please list all prescription and non-perscription medications including herbal supplements or remedies you are currently taking.

Medication Name	Condition prescribed for	Dosage	MM/YYYY Started

Allergies

Are you allergic to any medications or substances? Please list below:

Medication / Substance	Type of Allergic Reaction

Please attach a list of any additional allergies and/or medications if necessary

DENTAL HISTORY

General DDS: ____________________ Date of last exam: ____________________

Date of last cleaning: ____________________ Date of last dental xrays: ____________________

Referred by: ____________________

Are you required to take antibiotics prior to your dental appointments? ☐ YES ☐ NO

Are you apprehensive about dental treatment? ☐ YES ☐ NO

Do your gums bleed easily while brushing or flossing? ☐ YES ☐ NO

Do you have sores or swelling in your mouth? ☐ YES ☐ NO

Have you had any difficulty with dental treatment in the past? ☐ YES ☐ NO

Are you currently experiencing dental discomfort? ☐ Severe ☐ Moderate ☐ Mild ☐ None

Have You Had?	Yes	No
Periodontal (gum) treatment	☐	☐
Dental Implants	☐	☐
Partial or Full Dentures	☐	☐
Oral Surgery	☐	☐
Oral Cancer	☐	☐
Orthodontic Treatment (braces)	☐	☐
Your bite adjusted	☐	☐
A bite plane/guard or other appliance	☐	☐

Jaw Problems:	Yes	No
Temporomandibular Joint Disorder (TMJ)	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty opening, closing or chewing	☐	☐

Oral Habits:	Yes	No
Bite your lips or cheek frequently	☐	☐

How often do you floss? ____________________

How often do you brush your teeth? ____________________

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I authorize Dr. Richard Jirsa, DDS, MS or Dr. Todd Walker, DMD, MS to perform an oral examination and take any diagnostic images required for the purpose of diagnosis and treatment planning.

Signature of Patient: ____________________ **Date:** ____________________

Guardian Signature: ____________________ **Date:** ____________________