PATIENT REGISTRATION

☐ MR. ☐ MRS. ☐ MS. ☐ MISS. ☐ DR.

LAST NAME ____________________

FIRST NAME ____________________

MIDDLE INITIAL ____________________

BY WHICH NAME WOULD YOU LIKE TO BE CALLED?

____

RESIDENCE STREET ____________________

CITY __________ STATE ______ ZIP __________

TELEPHONE: RESIDENCE ____________________

BUSINESS ____________________

CELL ____________________

PAGER ____________________

BUSINESS ADDRESS ____________________

EMPLOYED BY ____________________

PRESENT POSITION __________ HOW LONG ______

PATIENT'S SOCIAL SECURITY# ____________________

PATIENT'S DATE OF BIRTH ____________________

NAME OF PHYSICIAN ____________________

TELEPHONE ____________________

NAME OF DENTIST ____________________

WHOM MAY WE THANK FOR THIS REFERRAL?

____

WHO IS RESPONSIBLE FOR PAYMENT OF THIS ACCOUNT? ____________________

ABOUT YOUR SPOUSE:

NAME ____________________

EMPLOYER ____________________

BUSINESS ADDRESS ____________________

BUSINESS TELEPHONE ____________________

PRESENT POSITION __________ HOW LONG ______

HAVE YOU OR A FAMILY MEMBER EVER BEEN SEEN IN OUR OFFICE ____________________.
NAME

DATE ____________________

DENTAL INSURANCE COVERAGE

EMPLOYEE NAME ____________________

DATE OF BIRTH ____________________

EMPLOYER ____________________ #YRS. ______

NAME OF INSURANCE COMPANY ____________________

____

ADDRESS OF INSURANCE COMPANY ____________________

____

____

GROUP NUMBER ____________________

SOCIAL SECURITY# ____________________

INSURANCE CO. PHONE# ____________________

MEDICAL INSURANCE COVERAGE

EMPLOYEE NAME ____________________

DATE OF BIRTH ____________________

EMPLOYER ____________________ #YRS. ______

NAME OF INSURANCE COMPANY ____________________

____

ADDRESS OF INSURANCE COMPANY ____________________

____

____

GROUP NUMBER ____________________

SOCIAL SECURITY# ____________________

INSURANCE CO. PHONE# ____________________

SOMEONE TO NOTIFY IN CASE OF EMERGENCY

(NOT LIVING WITH YOU):

NAME ____________________

ADDRESS ____________________

PHONE ____________________

MEDICAL HISTORY

NAME ______________________________ PREFERRED NAME ______________

AGE __________ MALE __________ FEMALE __________ BLOOD PRESSURE ______________

YES NO LUPUS
YES NO POSITIVE TEST FOR HIV
YES NO HEPATITIS
YES NO STROKE
YES NO ARTHRITIS
YES NO DIABETES
YES NO EPILEPSY
YES NO HEART TROUBLE ______________
YES NO RHEUMATIC FEVER
YES NO RHEUMATIC HEART DISEASE
YES NO HEART MURMUR
YES NO KIDNEY DISEASE
YES NO LIVER DISEASE
YES NO TUBERCULOSIS
YES NO OSTEOPOROSIS
YES NO EMPHYSEMA
YES NO HIGH BLOOD PRESSURE
YES NO RADIATION THERAPY BY X-RAY
YES NO CHEMOTHERAPY
YES NO ULCERS OR STOMACH TROUBLE
YES NO ASTHMA
YES NO GLAUCOMA
YES NO THYROID OR PARATHYROID DISORDER
YES NO CONTACT LENS
YES NO DOES ANYONE IN YOUR FAMILY HAVE DIABETES
YES NO DO YOU BLEED EASILY (FREE BLEEDER)
YES NO DO YOU BRUISE EASILY
YES NO ARTIFICIAL JOINT
YES NO SURGERY ______________
____
____
YES NO ANY SERIOUS ILLNESS NOW ______________
____
____

YES NO ALLERGIC TO DRUGS
WHAT ______________
WHEN ______________
____
____
YES NO ALLERGIC TO FOODS AND POLLEN
YES NO ALLERGIC TO DENTAL ANESTHETIC
WHAT ______________
WHEN ______________
YES NO TAKING TRANQUILIZERS
YES NO TAKING STEROIDS
YES NO TAKING MEDICATIONS NOW

PRESCRIBED	DOSAGE

OVER THE COUNTER	DOSAGE

YES NO ANY DRUG DEPENDENCY
YES NO AWARE OF RECENT WEIGHT CHANGE
YES NO SUBJECT TO FREQUENT URINATION
YES NO OFTEN THIRSTY
YES NO OFTEN EXHAUSTED OR FATIGUED
YES NO SUBJECT TO FREQUENT HEADACHES
YES NO A NERVOUS PERSON
YES NO IN GOOD HEALTH NOW
YES NO TAKING ANTI-PREGNANCY DRUGS
YES NO PRESENTLY IN MENOPAUSE
YES NO IN POST-MENOPAUSE
YES NO PREGNANT
YES NO NURSING
YES NO SMOKE
YES NO DRINK ALCOHOLIC BEVERAGES

DATE AND REASON FOR LAST PHYSICAL EXAMINATION ______________
____

PRESENTLY UNDER CARE OF DR. ______________

FOR THE TREATMENT OF ______________

PLEASE SIGN TOP LINE:

PATIENT SIGNATURE ______________ DATE ______
PATIENT SIGNATURE ______________ DATE ______
PATIENT SIGNATURE ______________ DATE ______
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PATIENT SIGNATURE ______________ DATE ______
PATIENT SIGNATURE ______________ DATE ______

DENTAL HISTORY

REASON FOR REFERRAL

____

____

____

YES NO PREVIOUS PERIODONTAL TREATMENT

____

____

YES NO WEAR PARTIALS/ DENTURES
HOW LONG?

YES NO GRIND YOUR TEETH
DAY NIGHT

YES NO CLENCH YOUR TEETH
DAY NIGHT

YES NO DO YOU USE DENTAL FLOSS?
HOW OFTEN? ____________________
HOW OFTEN DO YOU BRUSH YOUR TEETH? ____________________
TYPE OF BRUSH

YES NO DO YOUR GUMS BLEED OR HURT WHEN BRUSHING?

YES NO WATER PIC

YES NO ORTHODONTIC TREATMENT (BRACES)

EXPERIENCING ANY IMMEDIATE DENTAL PROBLEMS

____

YES NO DOES YOUR JAW CLICK OR POP?

YES NO AWARE OF PAIN IN FACIAL JOINTS?

YES NO DOES FOOD GET CAUGHT BETWEEN YOUR TEETH? ____________________

YES NO WHERE? ____________________

YES NO ARE ANY TEETH SENSITIVE TO HOT?
COLD ____ SWEETS ____ PRESSURE ____?

YES NO HAVE YOU HAD PROBLEMS WITH BAD BREATH?

YES NO HAVE YOU HAD PROBLEMS WITH SNORING?

YES NO RECENT DENTAL X-RAYS TAKEN
WHEN? ____________________

YES NO WERE THERE ANY COMPLICATIONS AFTER TOOTH REMOVAL?

____

YES NO HAVE MISSING TEETH BEEN REPLACED?
WHEN? ____________________
HOW? ____________________

YES NO ANYONE IN YOUR FAMILY LOST THEIR TEETH? WHO? ____________________
HOW MANY TEETH? ____________________

HOW DO YOU FEEL ABOUT YOUR TEETH IN GENERAL? ____

____

____

HAVE YOU HAD ANY UNPLEASANT DENTAL EXPERIENCES OR ANYTHING ABOUT DENTISTRY THAT YOU STRONGLY DISLIKE? ____

____

____

WHEN WAS YOUR LAST DENTAL VISIT? ____

WHAT WAS DONE? ____

HOW OFTEN DO YOU VISIT YOUR GENERAL DENTIST? ____

HOW LONG HAVE YOU BEEN WITH YOUR PRESENT DENTIST? ____

DATE OF LAST CLEANING? ____

DO YOU HAVE ANY QUESTIONS OR CONCERNS? ____

____

PATIENT SIGNATURE ____

DATE: ____

North Point Periodontics
A. Allen French, D.M.D., M.S.
M. Virginia Kirkland, D.M.D., M.S.
Diplomates
American Board of Periodontology

INFORMED CONSENT FOR EXAMINATION AND DIAGNOSIS

The purpose of this informed consent form is to insure that you have been informed of the periodontal treatment, as well as, any possible side effect from that treatment. It is not intended nor does it legally alter any recourse you may have from neglectful treatment by my staff or myself.

I ____, consent to and authorize Dr. A. Allen French or Dr. M. Virginia Kirkland to perform the following treatment consisting of but not limited to:

A. Periodontal examination: Periodontal probing; recession, mobility, furcation assessment; soft and hard tissue assessment; occlusal analysis.
B Radiographic examination: Obtaining necessary radiographs in order to aid examination, prognosis and diagnosis.
C. Prognosis and diagnosis: Short and long-term assessment of individual as well as overall dentition.

I certify that I have read and fully understand the above and consent to the operation that has been recommended. I also certify that all blanks or statements requiring insertion or completion were filled in and the inapplicable paragraphs were stricken before I signed.

Signed ____

Witness ______________________________________ date ____________.

CONSENT