NORTH PENN PERIODONTAL ASSOCIATES

PERIODONTAL DISEASE IS PRODUCED BY A COMBINATION OF MANY COMPLEX ELEMENTS; IT IS NECESSARY TO RESOLVE EVERY POSSIBLE CONTRIBUTING FACTOR. THE SUCCESS OF THERAPY IS DEPENDENT UPON THIS. THE FOLLOWING QUESTIONS ARE ALL ASSOCIATED WITH THE PROPER MANAGEMENT OF YOUR ORAL HEALTH. FOR YOUR WELFARE, PLEASE COMPLETE THIS CONFIDENTIAL FORM IN ITS ENTIRETY.

Name ____________________ Date of Birth __________ Marital Status __________

Address (Home) ____________________ City __________ State _____ Zip Code __________

S.S.# __________ Home Phone __________ Bus. Phone __________ Mobile Phone __________

Email __________ Occupation __________ Employer __________

Employer's Address ____________________

Name of Dentist __________ City __________ Tel # __________ Last Appt. __________

Name of Physician __________ City __________ Tel # __________ Last App. __________

Patient Referred By __________ Reason For This Visit __________

	Yes	No
Are you in good health?	❑	❑
Are you now under the care of a physician?	❑	❑
Are you taking any drug or medicine on a daily basis?	❑	❑

(Including aspirin/ibuprofen)? if yes, please list:

____
____
____
____
____

	Yes	No
Are you taking or *have you ever taken* Bisphosphonates (Fosamax or Actonel for osteoporosis, or chemotherapy for multiple myeloma, etc.)?	❑	❑
Have you had excessive bleeding requiring special treatment?	❑	❑
Do you have any known drug reactions?	❑	❑
Do you have any soreness in or around your mouth?	❑	❑
Do you have any soreness in or around your ears?	❑	❑
Are you pleased with the appearance of your teeth?	❑	❑
Do you smoke?	❑	❑
Do you premedicate prior to dental visits?	❑	❑

If yes, with what medication? __________

Are you allergic or have you reacted adversely to:

	Yes	No
Penicillin?	❑	❑
Aspirin?	❑	❑
Local anesthetics? ("Novacaine")?	❑	❑
Barbiturates, Sedatives, Sleeping Pills?	❑	❑
Sulfa Drugs?	❑	❑
Other Antibiotics?	❑	❑
Other Drugs?	❑	❑

Have you ever had any of the following conditions:

	Yes	No
Blood Diseases (Leukemia, HIV disease, AIDS)?	❑	❑
Anemia?	❑	❑
Respiratory Disorders (Tuberculosis)?	❑	❑
Rheumatism or Arthritis?	❑	❑
Hip or Knee replacement surgery?	❑	❑
Diabetes?	❑	❑
High or Low Blood Pressure? (Circle One)	❑	❑
Liver or Kidney Disorders (Hepatitis A,B or C)? (Circle One)	❑	❑
Rheumatic Fever?	❑	❑
Stroke?	❑	❑
Heart Disease? (Specify)	❑	❑
Pacemaker?	❑	❑
Have you had any other serious illnesses? (Specify)	❑	❑

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	Yes	No
Has anyone in your family ever had Diabetes?	❑	❑
Have you had psychiatric therapy?	❑	❑
Have you had "trenchmouth"?	❑	❑
Have you had any other periodontal treatment?	❑	❑
Have you had orthodontic therapy?	❑	❑
Do you clench or grind your teeth?	❑	❑
Do you snore?	❑	❑
Women: Are you pregnant?	❑	❑
Have you reached menopause?	❑	❑
Do you take birth control pills?	❑	❑

I understand that I am financially responsible for all charges.

Signed __________ Date __________
Patient (or Parent, if Minor)

ASSIGNMENT OF INSURANCE BENEFITS & RELEASE OF INFORMATION

I authorize payment of insurance benefits to NPPA for professional services rendered and authorize the release of any and all information necessary to process my insurance claim.

Signed __________ Date __________
Patient (or parent, if Minor)

Primary Dental Insurance

Insurance Co. Name:

Insurance Co. Address:

Insurance Co. Phone #:

Group # (Plan, Local or Policy #):

Insured's Name: Relation:

Insured's Birthday: / / Insured's SS #:

Insured's Employer:

Secondary Dental Insurance

Insurance Co. Name:

Insurance Co. Address:

Insurance Co. Phone #:

Group # (Plan, Local or Policy #):

Insured's Name: Relation:

Insured's Birthday: / / Insured's SS #:

Insured's Employer:

Medical Insurance

Insurance Co. Name:

Insurance Co. Address:

Insurance Co. Phone #:

Group # (Plan, Local or Policy #):

Insured's Name: Relation:

Insured's Birthday: / / Insured's SS #:

Insured's Employer:

North Penn Periodontal Associates
2100 North Broad Street
Suite 204
Lansdale, PA 19446
Phone: 215-368-5110
Fax: 215-368-2017

Acknowledgement of Receipt of Notice of Privacy Practices

I ________________________________, have received a copy of this office's Notice of Privacy Practices.

Print Name ____

Signature ____

Date ____

For Office Use Only

We attempt to obtain written acknowledgement of receipt for our Notice of Privacy Practices, but acknowledgement could not be obtained because:

___Individual refuses to sign

___Communications barriers prohibited obtaining acknowledgement

___An emergency situation prevented us from obtaining acknowledgement

___Other (Please Specify)

____

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____

Howard B. Gross, DDS, MScD
Diplomate of the American Board of Periodontology

NORTH PENN PERIODONTAL ASSOCIATES

PRACTICE LIMITED TO PERIODONTICS * IMPLANTS * ORAL MEDICINE

AUTHORIZATION FOR EMERGENCY CONTACT AND RELEASE OF PATIENT INFORMATION

IN CASE OF EMERGENCY PLEASE CONTACT:

NAME:____

EMERGENCY TELEPHONE NUMBER: ________________________

I, ______________________________ **HEREBY AUTHORIZE NORTH PENN PERIODONTAL ASSOCIATES TO DISCLOSE MY HEALTH INFORMATION TO:**

______**SPOUSE NAME**____________________________

______**PARENT NAME**____________________________

______**CHILD (OVER 18) NAME**________________________

OTHER: ____

I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA Privacy regulations. I understand that I may revoke this authorization at any time, and that my revocation is not effective unless it is in writing and received by the Privacy Official at North Penn Periodontal Associates. **(I understand that my revocation must be in writing.)** If I revoke this authorization, my revocation will not affect any actions taken by the periodontal practice before receiving my written revocation.

____________________________ ________________
Signature of Patient **Date**

____________________________ ________________
Signature of Parent or Guardian **Date**

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