SEASIDE PERIODONTICS, LLC
Periodontics & Dental Implantology

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Patient Information

Patient Name:

Date

Last,
First
M1 (Preferred Name)

Gender:

Family Status:

Social Security #-

Birth Date:

Phone (Home):

(Work):

Ext:

Best time to call:

Preferred appointment times:

Morning

Afternoon

Evening

Any Time

M

T

W

T

F

Address:

Street

Apartment #

City
State
Zip Code

Health Information

Date of Last Dental Visit:

Reason for this visit:

Have your ever had any of the following? Please check those that apply:

AIDS

Excessive Bleeding

Latex Allergy

Stomach Problems

Allergies

Fainting

Liver Disease

Stroke

Glaucoma

Mental Disorders

Tuberculosis

Growths

Nervous Disorders

Tumors

Anemia

Hay Fever

Pacemaker

Ulcers

Arthritis

Head Injuries

Pregnancy

Venereal Disease

Artificial Joints

Heart Disease
Due date:

Codeine Allergy

Asthma

Heart Murmur

Radiation Treatment

Penicillin Allergy

Blood Disease

Hepatitis

Respiratory
Do you or your spouse snore?

Cancer

High Blood Pressure
Problems

Diabetes

Jaundice

Rheumatic Fever

Dizziness

Kidney Disease

Rheumatism
List All Current Medications:

Epilepsy

• Have you ever had any complications following dental treatment?

Yes

No

If yes, please explain

• Have you been admitted to a hospital or needed emergency care during the past two years?

Yes

No

If yes, please explain:

• Are you now under the care of a physician?

Yes

No

If yes, please explain:

• Name of Physician

Phone:

• Do you have any health problems that need further clarification?

Yes

No

If yes, please explain:

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any
change in my health, I will inform the doctors at the next appointment without fail.

Date:

Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice?

Another patient, friend

Another patient, relative

Dental Office

Newspaper

School

Work

Radio Drop Down
Other

Name of person or office referring you to our practice:

Spouse or Responsible Party Information

The following is for:

the patient's spouse

the person responsible for payment

Name:

Male

Female

Married

Single

Child

Other

Social Security #

-

-

Birth Date:

Month
Day

Phone (Home): (

)

-

(Work):

)

-

Ext

Year
Best time to call:
Address:
Street
City
State
Zip Code

Employment Information

The following is for:

the patient

the person responsible for payment

Employer Name:
Occupation:
Address:
Street
City
State
Zip Code
Phone
Primary

Insurance Information

Name of Insured
Is insured a patient?

Yes

No

Last
First
M
Insured's Birth Date:
ID #
Group #
Insured's Address:
Insured's Employer Name:
Street
City
State
Zip Code
Address:

Street
City
State
Zip Code
Patient's relationship to insured:
Self
Spouse
Child
Other
Insurance Plan Name and Address:
Secondary
Name of Insured:
Is insured a patient?
Yes
No
Insured's Birth Date:
Last
First
M
ID #,
Group #
Insured's Address:
Insured's Employer Name:
Street
City
State
Zip code
Address:
Street
City
State
Zip Code
Patient's relationship to insured:
Self
Spouse
Child
Other

Insurance Plan Name and Address:

Consent for Services

As a condition of your treatment by this office financial arrangements must be made in advance The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patients account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay at the time services are rendered. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form. I understand that this office complies with the Healthcare Information Privacy Practices Act (HIPPA). A full explanation is available for me, at the front desk, should I require more information.

I have read the above conditions of treatment and payment and agree to their content.

Date

Relationship to Patient:

Signature of patient, parent or guardian

Date:

Relationship to Patient:

Signature of guarantor of payment/responsible party

Submit Form | Clear Form