ALBUQUERQUE
IMPLANT & PERIODONTAL CONSULTANTS

PERSONAL INFORMATION

Date					
Name				Preferred	
Date of Birth		SSN		Marital Status	
Address					
City		State		Zip	
Home Phone		Cell Phone		Work Phone	
Email					
I would like to receive appointment reminders by text & email: ____ Yes ____ No					
Employer			Occupation		
Referred By			General Dentist		

DENTAL INSURANCE INFORMATION

Insurance Company			
Subscriber Name		Subscriber SSN or ID#	
Subscriber Employer			
Subscriber Date of Birth		Group#	

SECONDARY DENTAL INSURANCE INFORMATION

Insurance Company			
Subscriber Name		Subscriber SSN or ID#	
Subscriber Employer			
Subscriber Date of Birth		Group#	

ACKNOWLEDGMENT OF FINANCIAL RESPONSIBILITY

1. We are providing a professional service at a reasonable fee. Payment is expected at the time of service. Payment may be made in the following ways:
   Cash Check Visa/ MasterCard/ Discover
2. Insurance estimates are provided as a courtesy. In the event that your insurance carrier pays less than the estimated amount, you are responsible for the unpaid balance.
3. We do not invoice patients. All balances must be paid at the time of service. This also allows us to keep our fees as low as possible.
4. Monthly Payment Program: We have contracted with Citi Card to provide a monthly payment program to our patients. This service allows you to make small monthly payments and has an interest free option.
5. Discounts: Our policy is not to discount for any reason. This allows our practice to keep our fees for everyone as low as possible.
6. Missed appointments: Appointments are considered confirmed at the time it is scheduled. I understand the office will try to contact me at the numbers I have provided in advance to confirm my appointment as a courtesy. I understand that the office reserves the right to charge for each broken appointment if adequate notice is not given. I understand that leaving a message after hours for the following day is not considered adequate notice since the office will not receive the message until the next working day.

I understand and agree to the above information

Signature:_____**Date:**_____

ACKNOWLEDGEMENT OF PRIVACY RIGHTS

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

1. Provide and coordinate my treatment among a number of health care providers who may be involved in the treatment directly or indirectly.
2. Obtain payment from third-party payers for my health care services.
3. Conduct normal health care operations such as quality assessment and improvement activities.

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the practices. I understand that my dental provider has the right to change the *Notice of Privacy Practices*, and that I may request to obtain a current copy.

I understand that I may request in writing that this office restrict how my private information is used or disclosed to carry out treatment, payment or health care operation. I understand that the office is not required to agree to my requested restrictions, but if the office does agree then it is bound to abide by such restrictions.

Signature:_____**Date:**_____

Relationship to patient (if signed by a representative of patient) _____

MEDICAL HISTORY **PATIENT NAME:**_____ **DATE:**_____

Although dental personnel primarily treat the area in your mouth, your mouth is part of your entire body. Health problems that you may have, or medication you may be taking could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Please Provide your height and weight Height_____ Weight_____

When did you last have a medical checkup? _____

Are you under a physician's care now? ☐ Yes ☐ No If yes, please explain _____

Have you been hospitalized or had a major operation? ☐ Yes ☐ No If yes, please explain _____

Have you ever had a serious head or neck injury? ☐ Yes ☐ No If yes, please explain _____

Do you consider your medical health to be good? ☐ Yes ☐ No

Have you had any difficulty with IVs or blood draws? ☐ Yes ☐ No

Are you on a special diet? ☐ Yes ☐ No

Do you use tobacco? ☐ Yes ☐ No

Do you drink alcohol regularly? ☐ Yes ☐ No

Do you use controlled substances? ☐ Yes ☐ No

Women: Are you
☐ Pregnant / Trying to get pregnant? ☐ Nursing
☐ Taking oral contraceptives?

Any family history of the following? ☐ Heart Disease ☐ Cancer ☐ Diabetes ☐ Gum Disease

Are you allergic to the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Sulfa

☐ Other _____

Do you have, or have had, any of the following?

☐ Alcoholism	☐ Dental Nervousness	☐ Hepatitis A, B or C	☐ Renal Dialysis
☐ AIDS/HIV Positive	☐ Depression	☐ Herpes	☐ Rheumatic Fever
☐ Alzheimer's Disease	☐ Diabetes	☐ High Blood Pressure	☐ Rheumatism
☐ Anaphylaxis	☐ Drug Addiction	☐ Hives or Rash	☐ Scarlet Fever
☐ Anemia	☐ Easily Winded	☐ HPV	☐ Shingles
☐ Angina / Chest Pain	☐ Emphysema / COPD	☐ Hypoglycemia	☐ Sickle Cell Disease
☐ Arthritis / Gout	☐ Epilepsy / Seizures	☐ Irregular Heartbeat	☐ Sinus Trouble
☐ Artificial Heart Valve	☐ Excessive Bleeding	☐ Kidney Problems	☐ Sleep Apnea / CPAP
☐ Artificial Joint / Pre-Med	☐ Fainting Spells / Dizziness	☐ Leukemia	☐ Stomach/Intestinal Disease
☐ Asthma	☐ Frequent Cough	☐ Liver Disease	☐ Stroke
☐ Blood Disease	☐ Frequent Headaches	☐ Low Blood Pressure	☐ Swelling of Limbs
☐ Blood Transfusion	☐ Genital Herpes	☐ Lung Disease	☐ Thyroid Disease
☐ Breathing Problems	☐ Glaucoma	☐ Mitral Valve Prolapse	☐ Tuberculosis/PPD Positive
☐ Bruise / Bleed Easily	☐ Hay Fever	☐ Osteoporosis	☐ Tumors or Growths
☐ Cancer	☐ Heart Attack / Failure	☐ Pain in Jaw Joints	☐ Ulcers
☐ Chest Pains	☐ Heart Murmur / Pre-Med	☐ Persistent Cough	☐ Unexplained Weight Loss
☐ Cold Sores / Fever Blisters	☐ Heart Pacemaker	☐ Prosthetic Joint	☐ Venereal Disease
☐ Congenital Heart Disorder	☐ Heart Trouble / Disease	☐ Psychiatric Care	☐ Yellow Jaundice
☐ Convulsions	☐ Hemophilia	☐ Radiation Treatments	

Have you ever had any serious illness not listed above? ☐ Yes ☐ No If yes, please explain

_____

_____

DENTAL HISTORY

The following information is required to help with your dental diagnosis. Thank you for answering the following questions.

General Dentist _____

Referring Doctor _____

Have you been experiencing pain from your mouth lately? ☐ Yes ☐ No

Are you experiencing pain from your mouth at this time? ☐ Yes ☐ No

Have you had swollen areas of the gum lately? ☐ Yes ☐ No

When did you last have your teeth cleaned? _____

How often have you had your teeth cleaned in the last 5 years? _____

Do your gums bleed? ☐ Yes ☐ No

Do your gums bleed when you brush? ☐ Yes ☐ No

Are your teeth sensitive to hot, cold or sweets? ☐ Yes ☐ No Which teeth?_____

How often do you brush your teeth? _____

What type of toothbrush do you use? ☐ Electric ☐ Manual

How often do you floss your teeth? _____

Do you smoke? ☐ Yes ☐ No How much?_____

What? _____

Have you ever had periodontal (gum) treatments? ☐ Yes ☐ No

When:_____

Doctor's name:_____

Treatment performed:_____

GENERAL QUESTIONS

Do you wish to talk privately about any problem? ☐ Yes ☐ No

Do you currently take any medications? ☐ Yes ☐ No If yes, please list all medications and why you are taking them:

_____

_____

_____

_____

To the best of my knowledge, the questions on these forms have been accurately answered. I understand that providing incorrect medical history information can be dangerous to the patient's health. It is my responsibility to inform the dental office of any changes in the patient's medial status.

Print Name _____ Date_____

Signature_____