Periodontal Associates,LTD Fayez G. Badlissi DMD PC
Jeffrey B. Shapiro DMD
189 Governor Street
Providence RI 02906
(401)421-6464
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Medical & Dental History Form

Chart #. _____
FOR OFFICE USE ONLY

Patient Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ SS #. _____ Prev. Visit: _____

Email Address: _____ Best time to call: _____

Phone: _____ (Home) _____ (Work) _____ (Ext) _____ (Mobile) _____ (Fax) _____ (Other)

Address: _____
_____ (City) _____ (State) _____ (Zip Code)

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Phone: _____

Address: _____
_____ (City) _____ (State) _____ (Zip Code)

Who may we thank for referring you?

_____

Spouse Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment ☐ neither-not applicable

Name: Last First MI Preferred Name

Title: Mr/Ms/Mrs/etc Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: Email Address:

Phone: Home Work Ext Mobile Best time to call:

Address:

City State Zip Code

Person Responible for Account

The following is for: ☐ the patient's spouse ☐ the person responsible for payment ☐ neither-not applicable

Name: Last First MI Preferred Name

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Primary Dental Insurance

Name of Insured: _____ (Last) _____ (First) _____ (MI)

Insured's Birth Date: _____ ID #. _____ Group #. _____

Insured's Address: _____ _____

_____ (City) _____ (State) _____ (Zip Code)

Insured's Employer Name: _____

Employer Address: _____ _____

_____ (City) _____ (State) _____ (Zip Code)

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____

_____ (City) _____ (State) _____ (Zip Code)

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Secondary Dental Insurance

Name of Insured: Last First MI

Insured's Birth Date: ID #. Group #.

Insured's Address:

City State Zip Code

Insured's Employer Name:

Employer Address:

City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name:

Insurance Address:

City State Zip Code

In the event of an emergency, who should we contact?

Your Primary Care Physician's name, address, & phone number:

Please take a moment to let us know about your medical and dental history so we may serve you more effectively and in a way that watches out for your overall health and well-being.

Would you consider yourself to be in fairly good health?

◯ Yes ◯ No

Within the past year, have there been any changes in your general health?

◯ Yes ◯ No

Are you taking any prescription/over-the counter or supplimental drugs?

◯ Yes ◯ No

If yes, please list each one:

Have you taken or are you currently taking Fosamax or any other bisphosphonate?

◯ Yes ◯ No

WOMEN ONLY: Are you pregnant?

◯ Yes ◯ No

If Yes, when is the due date?

Are you nursing?

◯ Yes ◯ No

Please list any serious medical condition(s) that you have ever had.

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Please indicate if you have experienced any of the following:

- ☐ Allergies
- ☐ Angina
- ☐ Aspirin Allergy
- ☐ Cancer
- ☐ Diabetes
- ☐ Epinephrine Allergy
- ☐ Fainting
- ☐ Head Injuries
- ☐ Heart Valve Repl.
- ☐ HIV
- ☐ Latex Allergy
- ☐ Lyme Disease
- ☐ Morphine Allergy
- ☐ Mycin Family Allergy
- ☐ Pacemaker
- ☐ Pregnancy
- ☐ Respiratory Problems
- ☐ Sinus Problems
- ☐ Substance Abuse
- ☐ Thyroid condition
- ☐ Ulcers
- ☐ Alzheimers-Mem. loss
- ☐ Arthritis
- ☐ Asthma
- ☐ Codeine Allergy
- ☐ Dizziness
- ☐ Erythromycin Allergy
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hypertension
- ☐ Liver Disease
- ☐ MEDS-See Pt Note
- ☐ Motrin Allergy
- ☐ Nervous Disorders
- ☐ Penicillin Allergy
- ☐ Pre-Med
- ☐ Rheumatic Fever
- ☐ Stomach Problems
- ☐ Sulfa Allergy
- ☐ Tuberculosis
- ☐ Venereal Disease
- ☐ Anemia
- ☐ Artificial Joints
- ☐ Blood Disease
- ☐ Coumadin Allergy
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Hay Fever
- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Low Blood Pressure
- ☐ Mental Disorders
- ☐ MVP
- ☐ Other-See Pt Note
- ☐ Percodan Allergy
- ☐ Radiation Treatment
- ☐ Rheumatism
- ☐ Stroke
- ☐ Tetracycline Allergy
- ☐ Tumors

General Dentist's name, address, & phone number:

What is the reason for your dental visit today?

When was your last visit to your dentist ?

What service was provided?

Date of last cleaning?

Date of last x-rays?

Please mark any of the following to indicate Yes in response to the question:

- ☐ Do you require antibiotics before dental treatment?
- ☐ Do your gums bleed when you brush or floss?
- ☐ Do your teeth experience sensitivity to cold or hot temperatures?
- ☐ Are any of your teeth currently causing you pain?
- ☐ Do you grind your teeth (either consciously or during sleep)?
- ☐ Are any of your teeth loose, or are you concerned about any teeth loosening?
- ☐ Do you currently have any dental implants, dentures, or partials?
- ☐ Have you had root canal treatment?
- ☐ Have you had orthodontic treatment?
- ☐ Have you had oral surgery?

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How frequently do you brush your teeth?

◯ 3 (+) a day ◯ Twice a day ◯ Once a day ◯ Weekly ◯ Seldom

What type of brush do you use?

How frequently do you floss your teeth?

◯ 1 (+) a day ◯ 2 - 6 weekly ◯ 1 - 6 monthly ◯ Seldom ◯ Never

Other cleaning aids?

◯ Yes ◯ No

If yes, what types?

☐ I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Authorization

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

Signature of patient, parent, or guardian:

Signature: _____ Date:

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Relationship to Patient:

Response Date: