PATIENT INFORMATION

NAME _____

HOME ADDRESS _____

CITY _____ **STATE** _____ **ZIP CODE** _____

HOME PHONE _____ **WORK PHONE** _____ **EXT** _____

CELL PHONE _____ **RECEIVE TEXT MESSAGE FOR CONFIRMING?** ☐ **YES** ☐ **NO**

YOUR E-MAIL ADDRESS FOR CONFIRMATION _____

YOUR PHARMACY PHONE NUMBER _____

EMPLOYER _____ **OCCUPATION** _____

BIRTHDATE _____ **SSN** _____ **SEX** _____

I AM ALLERGIC TO _____

WHOM MAY WE THANK FOR REFERRING YOU TO US? _____

WHO IS YOUR GENERAL DENTIST _____

WHOM MAY WE CONTACT IN CASE OF EMERGENCY? _____

SPOUSE'S NAME _____ **WORK PHONE** _____ **EXT** _____

WHO IS FINANCIALLY RESPONSIBLE FOR THIS BILL? _____

DRIVER'S LICENSE NUMBER _____ **STATE** _____

I have read all of the information on both sides of this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status of above information.

SIGNATURE _____ DATE _____

PARENT (if minor) _____ DATE _____

MY DENTAL INSURANCE

INSURANCE CO. _____
INSURANCE ADDRESS _____
_____
INSURANCE GROUP # _____
INSURANCE PHONE # _____

MY SPOUSE'S DENTAL INSURANCE

INSURANCE CO. _____
INSURANCE ADDRESS _____
_____
INSURANCE GROUP # _____
INSURANCE PHONE # _____

EMPLOYER NAME _____
SOCIAL SECURITY # _____
DATE OF BIRTH _____

☐ I **AM NOT** COVERED BY ANY DENTAL INSURANCE (Either mine or other family member's) AT THIS TIME

PLEASE COMPLETE REVERSE SIDE

MEDICAL HEALTH QUESTIONNAIRE

YOUR GENERAL DENTIST_____

YOUR MEDICAL PHYSICIAN'S NAME _____ YOUR AGE _____

YOUR PHARMACY PHONE NUMBER _____ WEIGHT _____

WOULD YOU DESCRIBE YOUR PRESENT HEALTH? (PLEASE CHECK ONE) HEIGHT _____

☐ EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR ☐ DON'T KNOW

HAVE YOU BEEN A PATIENT IN A HOSPITAL DURING THE PAST TWO YEARS? ☐ YES ☐ NO

DO YOU TAKE ANY MEDICINES? (Including Vitamins or Supplements, Hormones or Antacids) ☐ YES ☐ NO

IF SO, LIST HERE_____

DO YOU TAKE A BLOOD THINNER DAILY? (Coumadin, Plavix, Aspirin, etc.) ☐ YES ☐ NO

DO YOU CURRENTLY TAKE ANY BISPHOSPHONATES? (Fosamax, Boniva, Actonel, etc.) ☐ YES ☐ NO

ARE YOU ALLERGIC TO PENICILLIN OR ANY OTHER MEDICINES OR DRUGS? ☐ YES ☐ NO

IF SO, LIST HERE_____

DOES ASPIRIN OR IBUPROFEN (MOTRIN) IRITATE YOUR STOMACH? ☐ YES ☐ NO

HAVE YOU EVER HAD AN ADVERSE REACTION TO AN ANESTHETICS, SEDATIVES OR NARCOTICS? ☐ YES ☐ NO

IF SO, LIST HERE_____

HAVE YOU EVER HAD EXCESSIVE BLEEDING THAT REQUIRED SPECIAL TREATMENT? ☐ YES ☐ NO

HAVE YOU BEEN DIAGNOSED AS HAVING ANY IMMUNODEFICIENCY, HIV or AIDS? ☐ YES ☐ NO

ARE YOU REQUIRED, DUE TO YOUR HEALTH, TO RESTRICT YOUR WORK OR ACTIVITY IN ANY WAY? ☐ YES ☐ NO

DO YOU USE TOBACCO? IF SO, HOW MUCH: _____PER DAY ☐ YES ☐ NO

DO YOU DRINK ALCOHOL? IF SO, HOW MUCH: _____PER DAY ☐ YES ☐ NO

DO YOU HAVE ANY HISTORY OF ANY TYPE OF SUBSTANCE ABUSE? ☐ YES ☐ NO

CHECK ONLY IF YOU MAY HAVE HAD:

☐ HEART TROUBLE	☐ HIGH BLOOD PRESSURE	☐ PERSISTENT COUGH
☐ CONGENITAL HEART LESIONS*	☐ LOW BLOOD PRESSURE	☐ SINUS TROUBLES
☐ HEART MURMUR*	☐ GLAUCOMA	☐ TUBERCULOSIS
☐ PROLAPSED MITRAL VALVE*	☐ DIABETES	☐ ASTHMA
☐ HEART SURGERY	☐ HEPATITIS or JAUNDICE	☐ EPILEPSY
☐ RHEUMATIC FEVER*	☐ ULCERS	☐ ARTHRITIS
☐ CARDIAC PACEMAKER	☐ KIDNEY DISEASE*	☐ STROKE
☐ HEART VALVE PROSTHESIS*	☐ PSYCHIATRIC CARE	☐ JOINT REPLACEMENT PROSTHESIS*

*HAS A PHYSICIAN DIRECTED YOU TO TAKE ANTIBIOTICS PRIOR TO HAVING YOUR TEETH CLEANED? ☐ YES ☐ NO

DO YOU HAVE ANY DISEASE, CONDITION OR PROBLEM NOT LISTED ABOVE THAT YOU FEEL WE SHOULD KNOW ABOUT?

IF SO, PLEASE EXPLAIN:_____

_____ _____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE

Coatoam Periodontal Associates
195 West Highland Street
Altamonte Springs, FL 32714

FINANCIAL POLICY

We are committed to providing you with the best possible care. If you have dental insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals we need your assistance, and understanding of our payment policy.

Payment for services is due at the time that services are rendered. We accept cash, checks, MasterCard and Visa. We will make every effort possible to assist you with your particular insurance coverage. If you desire, we will prepare and submit your insurance claim form as a courtesy to you. We can also send a pre-treatment estimate to your insurance company so that you know up front what your portion of the treatment will be (Pre-estimates make take up to 6 weeks to return from your insurance company).

We do ask the patient to pay for their portion at the time services are rendered. If you decide not to wait for a pre-treatment estimate we will have you put 30% down and then submit to insurance. Ultimately, you are responsible for any balance not paid by the insurance company. Should no insurance payment be paid within 60 days of a submitted claim, the fee will become the responsibility of the patient and subject to a finance charge of 1.5% per month after 90 days.

We will gladly discuss your recommended treatment and answer questions relating to your insurance. You must realize however:

1) Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract and are not an in-network provider for any insurance company.

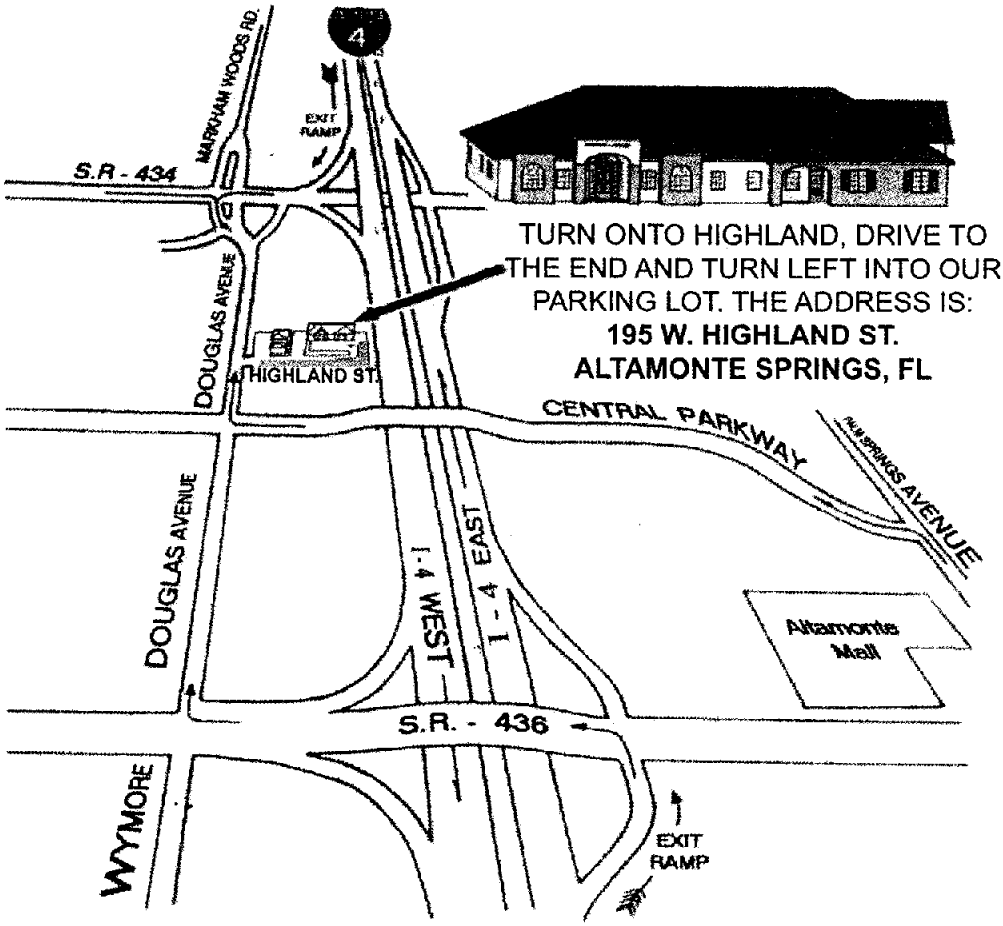
2) Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

3) Returned checks are subject to a service charge.

4) Charges may also be made for broken appointments cancelled without 48 hours notice.

5) By signing this agreement you are entering into a contract with Coatoam Periodontal Associates, PLLC. In the event we are required to engage the services of attorney to collect any unpaid balance, Coatoam Periodontal Associates, PLLC shall be entitled to recover its attorney's fees and costs.

Patient signature_____Date_____



Periodontal Pathology
Gingivitis
Periodontitis
Mucogingival Insufficiency
Missing Teeth
Pockets
Oral Lesions
Occlusal Trauma
Malodor

Treatment
Flap Surgery
Gingivectomy
Implants
Gingival Grafting
Bone Grafting
Frenulectomy
Biopsy
Bacteriological Assay
Occlusal Adjustment
Subgingival Medication
Scaling and Curettage
Anxiolytic Pre-Med
Intravenous Sedation
Pocket Charting
Radiographic Evaluation
Periodontal Maintence

Odontogenic
Crown Lengthening
Surgical Exposure
Bracket Ligation
Radicular Pathology
Root Fracture
Root Resorption
Root Perforation
Root Resection
Extraction
Socket Grafting
Periapical Pathology
Apicoectomy
Retrograde filling
Traumatic Evulsion
Reimplantation

Tissue Engineering
Ridge Augmentation
Sinus Augmentation
Ridge-Split Procedure

Clinical Anomalies
Neurologic Pain
Xerostomia
Malodor
Abscess

Gingiva
Grafting
Frenulectomy
Gingivectomy
Recession
Clefting
Bleeding
Swelling
Abscess
Infection
A.N.U.G.
Ulceration
Leukoplakia
Laceration
Hyperplasia
Discoloration
Pigmentation

Occlusion
Tooth Mobility
Drifting Teeth
Fremitus
Adjustment
TMD
Appliance
Splinting

Implantology
Implant Placement
Peri-Implantitis
Implant Removal
Loose Components
Broken Components

Orthodontology
Pre-Orthodontic Evaluation
Exposure and Ligation
Circumferential Fibrotomy
Implant Space Analysis
Narrow Space Implant
Minor Tooth Movement
Root Extrusion

Oral Pathology
Biopsy
Incision and Drainage
Infection
Neoplasm
Gingival Tumor
Fibroma
Cysts
Ulceration
Leukoplakia
Candidiasis