TAMPA BAY
PERIODONTICS AND IMPLANT DENTISTRY

James G. Wilson, DMD
Board Certified Periodontist
Matthew T. Waite, DDS, MS
Kailand C. Cosgrove, DMD, MS
Elsy D. Orellana DMD, MSD

# MEDICAL/DENTAL HISTORY

Do you have or have you ever had: YES NO

1. Hospitalization for illness or injury _____ ☐ ☐
2. An allergic reaction to
   - ☐ aspirin, ibuprofen, acetaminophen, codeine
   - ☐ penicillin ☐ erythromycin
   - ☐ tetracycline ☐ sulfa
   - ☐ local anesthetic ☐ fluoride
   - ☐ metals (nickel, gold, silver, _____)
   - ☐ latex
   - ☐ other _____

Pharmacy Name: _____
Pharmacy Address: _____
Pharmacy Phone Number: _____
Restorative Dentist: _____

3. Are you in good health? . . . . . Yes ☐ No ☐
4. Date of last physical examination _____ Are you currently being treated by a physician? . . . . Yes ☐ No ☐
   Physician Name: _____ Physician Number: _____
5. Are you taking any prescription drugs or medications? . . . . . Yes ☐ No ☐
   If yes, please list _____
6. Are you taking any over-the-counter preparations or medications (example: aspirin, vitamins, supplements)? . . . . . Yes ☐ No ☐
   If yes, please list _____
7. Indicate which of the following you have had or have at the present:

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Heart disease or attack | Yes ☐ No ☐ | Allergies or hives | Yes ☐ No ☐ | Anemia | Yes ☐ No ☐ |
| High blood pressure | Yes ☐ No ☐ | Sinus trouble | Yes ☐ No ☐ | Prolonged bleeding | Yes ☐ No ☐ |
| Angina | Yes ☐ No ☐ | Thyroid disease | Yes ☐ No ☐ | Hemophilia | Yes ☐ No ☐ |
| Congenital heart lesions | Yes ☐ No ☐ | Liver disorder | Yes ☐ No ☐ | Immune system disorder | Yes ☐ No ☐ |
| Artificial heart valve | Yes ☐ No ☐ | Hepatitis | Yes ☐ No ☐ | AIDS/HIV positive | Yes ☐ No ☐ |
| Heart pacemaker | Yes ☐ No ☐ | Diabetes | Yes ☐ No ☐ | Fainting or dizziness | Yes ☐ No ☐ |
| Heart surgery | Yes ☐ No ☐ | Hemoglobin A1c. | _____ | Epilepsy or seizures | Yes ☐ No ☐ |
| Hip/Knee replacement | Yes ☐ No ☐ | Hypoglycemia | Yes ☐ No ☐ | Cancer | Yes ☐ No ☐ |
| Other joint replacement | Yes ☐ No ☐ | Arthritis or rheumatism | Yes ☐ No ☐ | Chemotherapy | Yes ☐ No ☐ |
| Stroke | Yes ☐ No ☐ | Osteoporosis | Yes ☐ No ☐ | Radiation treatment | Yes ☐ No ☐ |
| Kidney disorder | Yes ☐ No ☐ | Glaucoma | Yes ☐ No ☐ | Mental disorder | Yes ☐ No ☐ |
| Ulcers | Yes ☐ No ☐ | Cold sores/fever blisters | Yes ☐ No ☐ | Anxiety | Yes ☐ No ☐ |
| Emphysema | Yes ☐ No ☐ | Venereal disease | Yes ☐ No ☐ | Drug addiction | Yes ☐ No ☐ |
| Asthma | Yes ☐ No ☐ | Blood disease/disorder | Yes ☐ No ☐ | Alcohol addiction | Yes ☐ No ☐ |

8. Do you have any disease, condition, or problem not listed? . . . . . Yes ☐ No ☐
   If yes, please explain _____
9. Do you currently or have you in the past taken Fosamax, Actonel, Boniva, Prolia or Reclast for osteoporosis/osteopenia or were you treated with the medications Zometa or Aredis for chemotherapy? . . . . . Yes ☐ No ☐
10. Do you currently smoke or use smokeless tobacco? . . . . . Yes ☐ No ☐
11. Have you previously smoked or used smokeless tobacco? . . . . . Yes ☐ No ☐
12. Date of last dental visit . . . . . _____
13. Have you had any problems associated with previous dental treatment? . . . . . Yes ☐ No ☐
14. Have you ever had periodontal treatment? . . . . . Yes ☐ No ☐
15. Have you ever worn braces? . . . . . Yes ☐ No ☐
16. Do you clench or grind your teeth? . . . . . Yes ☐ No ☐
17. Do you experience pain in your jaw joints or facial muscles? . . . . . Yes ☐ No ☐
18. Do you wear any removable dental appliances? . . . . . Yes ☐ No ☐
19. Do you have any specific questions or concerns about your oral health? . . . . . Yes ☐ No ☐
    If yes, please explain _____

**WOMEN**

20. Are you pregnant? . . . . . Yes ☐ No ☐
21. Are you taking birth control pills? . . . . . Yes ☐ No ☐

| SIGNATURE - PATIENT/GUARDIAN | DATE |
|---|---|
| SIGNATURE - DOCTOR | DATE |

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PLEASE PRINT

# CONFIDENTIAL INFORMATION QUESTIONNAIRE

| PATIENT'S LEGAL NAME LAST FIRST MI | DATE OF BIRTH | SEX | SSN |
|---|---|---|---|
| | | | |

| PREFER TO BE CALLED | HOME PHONE | CELL PHONE |
|---|---|---|
| | | |

| PATIENT'S ADDRESS STREET APT # CITY STATE ZIP/POSTAL CODE | E-MAIL |
|---|---|
| | |

| MARITAL STATUS<br>☐S ☐M ☐W ☐D<br>☐UNDER AGE 18 | PATIENT'S/GUARDIAN'S EMPLOYER | OCCUPATION |
|---|---|---|
| | | |

| WORK ADDRESS STREET APT # CITY STATE ZIP/POSTAL CODE | WORK PHONE |
|---|---|
| | |

| SPOUSE/GUARDIAN LAST FIRST MI | SPOUSE/GUARDIAN EMPLOYER | OCCUPATION |
|---|---|---|
| | | |

| SPOUSE'S WORK ADDRESS STREET APT # CITY STATE ZIP/POSTAL CODE | WORK PHONE |
|---|---|
| | |

| OTHER FAMILY MEMBERS THAT ARE PATIENTS HERE | WHOM CAN WE THANK FOR REFERRING YOU TO OUR OFFICE? |
|---|---|
| | |

# EMERGENCY CONTACT INFORMATION

**PERSON WE MAY CONTACT IN CASE OF AN EMERGENCY (OTHER THAN YOUR FAMILY HOME)**

| NAME | RELATIONSHIP |
|---|---|
| | |

| HOME PHONE | WORK PHONE | CELL PHONE |
|---|---|---|
| | | |

## Methods of Communication

Unless you indicate a preference to **not** be contacted by a method, our office utilizes multiple methods of communication with our patients.

# REQUEST FOR CONFIDENTIAL COMMUNICATION

AS MY DENTAL CARE PROVIDER, YOU MAY DO THE FOLLOWING WITH MY PERMISSION:

| | YES | NO |
|---|---|---|
| Contact me at home/Leave messages on my home voicemail | ❍ | ❍ |
| Contact me via cell phone/Leave messages on my cell phone voicemail | ❍ | ❍ |
| Contact me via e-mail | ❍ | ❍ |

# CONFIRMATIONS

**DO YOU PREFER A CONFIRMATION CALL**

☐ No, it is unnecessary ☐ Yes, it is a helpful reminder

☐ _____ initials

I provide Tampa Bay Periodontics and Implant Dentistry and their staff consent to discuss limited Personal Health Information with anyone who transports me to and from an appointment when I am sedated. Examples might include how your treatment went or instructions for any post-treatment care.

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# DENTAL INSURANCE & FINANCIAL INFORMATION

| **INSURANCE COVERAGE** ☐YES ☐NO | INSURANCE COMPANY NAME | INSURANCE ADDRESS | INSURANCE PHONE |
|---|---|---|---|
| SUBSCRIBER'S NAME | PATIENT'S RELATIONSHIP TO SUBSCRIBER ☐SELF ☐SPOUSE ☐DEPENDENT | SUBSCRIBER'S BIRTH DATE | SSN |
| GROUP/PROGRAM NUMBER | EMPLOYER (IF DIFFERENT FROM ABOVE) | | EMPLOYER'S ADDRESS |
| **SECONDARY COVERAGE** ☐YES ☐NO | INSURANCE COMPANY NAME | INSURANCE ADDRESS | INSURANCE PHONE |
| SUBSCRIBER'S NAME | PATIENT'S RELATIONSHIP TO SUBSCRIBER ☐SELF ☐SPOUSE ☐DEPENDENT | SUBSCRIBER'S BIRTH DATE | SSN |
| GROUP/PROGRAM NUMBER | EMPLOYER (IF DIFFERENT FROM ABOVE) | | EMPLOYER'S ADDRESS |

# RELEASE INFORMATION

**YOU MAY DISCUSS MY HEALTHCARE WITH**

| | YES | NO | OTHERS (PLEASE PRINT) |
|---|---|---|---|
| Health Care Providers | ☐ | ☐ | 1. |
| Insurance Companies | ☐ | ☐ | 2. |

# NOTICE OF PRIVACY PRACTICES

☐ _____ I have received a copy of the Notice of Privacy Practices of Tampa Bay Periodontics and Implant Dentistry. I hereby authorize, as indicated by my initials, Tampa Bay Periodontics and Implant Dentistry to use and disclose my protected health information for any necessary clinical, financial, and insurance purpose, as authorized in the patient consent form.

# ASSIGNMENT & RELEASE

I hereby authorize (1) any available insurance benefits to be paid directly to my dentist, (2) the release of my dental heath care information in connection with any insurance claim for such care, (3) my dentist to use my dental records in any professional manner that he/she so determines, (4) the making of videotapes, photographs, and x-rays of the dental treatment that I receive before, during and after such treatment (collectively "My Images"), and (5) my dentist to use My Images in scientific papers, demonstrations and/or presentations without compensation to me. If I am signing this form as the guardian of a patient then the above authorization is on behalf of such patient.

I acknowledge and agree that if certain costs of my dental care are not covered by insurance, I am financially responsible and obligated to pay my dentist such uninsured cost in accordance with the payment terms and policies of my dentist. If I am signing this form as the guardian of the dentist's patient, the dentist agrees that my signature does not make me personally liable for the payment of any uninsured costs.

Finally, by signing below I acknowledge my understanding of the risks and limitations involved with the dental treatment that I am to receive or that the patient is to receive if I am signing as such patient's guardian.

| SIGNATURE - PATIENT/GUARDIAN | DATE |
|---|---|
| WITNESS SIGNATURE | DATE |

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Name:_____ Date:_____

Medication: _____

Purpose: _____ Prescribed by: _____

Medication: _____

Purpose: _____ Prescribed by: _____

Medication: _____

Purpose: _____ Prescribed by: _____

Medication: _____

Purpose: _____ Prescribed by: _____

Supplement: _____

Purpose: _____ Prescribed by: _____

Supplement: _____

Purpose: _____ Prescribed by: _____

Supplement: _____

Purpose: _____ Prescribed by: _____

**NOTES:** _____

_____

_____

_____

_____

_____