PerioWest™
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Diplomate, American Board of Periodontology
(952) 567-7457

Patient Information

Title First Name M.I. Last Name Date
I prefer to be called Email:
Address City State Zip
Home Phone Cell Phone Business Phone Ext.
Preferred Contact # Social Security # **Gender** ☐ Male ☐ Female
Date of Birth / / **Marital Status** ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
How did you find out about us?
Other family members seen by us:

Emergency Contact

Title First Name M.I. Last Name Suffix
Relationship to Patient
Home Phone Cell Phone Business Phone Ext.

Responsible Party / Patient

Who will be responsible for your account? ☐ Self ☐ Spouse ☐ Father ☐ Mother ☐ Other:
Title First Name M.I. Last Name Suffix
Address City State Zip
Home Phone Business Phone Ext.
Date of Birth / / Social Security # Driver's License #
Employer

Primary Dental Insurance

Do you have a Primary Insurance? ☐ Yes ☐ No Does it have Dental Coverage? ☐ Yes ☐ No
Company Name
Company Address City State Zip
Company Phone # **Individual ID# or SSN** **Group #** (Plan, Local or Policy #)
Subscriber's Name **Relationship to Patient**
Subscriber's Date of Birth / / **Subscriber's Employer**
Subscriber's Employee Address

Secondary Dental Insurance

Do you have a Secondary Insurance? ☐ Yes ☐ No Does it have Dental Coverage? ☐ Yes ☐ No
Company Name
Company Address City State Zip
Company Phone # **Individual ID# or SSN** **Group #** (Plan, Local or Policy #)
Subscriber's Name **Relationship to Patient**
Subscriber's Date of Birth / / **Subscriber's Employer**
Subscriber's Employee Address

Dental Information

Previous or Referring Dentist: Phone Number:
When was your last dental visit? What was done?
When were x-rays taken last? **When was your last dental cleaning?**
Reason for today's visit: **Are you in pain?** ☐ Yes ☐ No For how long?
Please rate your current dental health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor
How do you feel about your smile?
How many times a day do you brush? **How many times a week do you floss?**
What type of toothbrush do you use? ☐ Hard ☐ Medium ☐ Soft
Are you fearful of dental treatment? ☐ Yes ☐ No Please explain:
Have you ever had trouble getting numb or had reactions to local anesthetic? ☐ Yes ☐ No
Please describe:

Do your gums bleed?	☐ Yes	☐ No
Is your mouth dry?	☐ Yes	☐ No
Teeth sensitive to heat, cold, sweets, brushing, or flossing?	☐ Yes	☐ No
Have you noticed any bad tastes or bad breath?	☐ Yes	☐ No
Have you ever had periodontal (gum) treatments?	☐ Yes	☐ No
Have you had orthodontic (braces) treatment?	☐ Yes	☐ No
Does food tend to become caught between your teeth?	☐ Yes	☐ No
Have you had any problems associated with previous dental treatment?	☐ Yes	☐ No
Do you have earaches or neck pains?	☐ Yes	☐ No
Do you have any clicking, popping or discomfort in the jaw?	☐ Yes	☐ No
Have you noticed any loose or shifting teeth?	☐ Yes	☐ No
Have any of your family members had significant dental treatment or tooth loss?	☐ Yes	☐ No
Would you be concerned if you lost your teeth and had to wear false teeth?	☐ Yes	☐ No
Do you clench or grind your teeth?	☐ Yes	☐ No
Have you had headaches on a regular basis in the morning, evening, or after eating?	☐ Yes	☐ No
Have you had your bite adjusted?	☐ Yes	☐ No
Do you have sores or ulcers in your mouth?	☐ Yes	☐ No
Do you wear dentures or partials?	☐ Yes	☐ No
Have you ever had a serious injury to your head or mouth?	☐ Yes	☐ No
Do you participate in active recreational activities?	☐ Yes	☐ No

Health History

Please rate your current physical health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Date of last physical exam **Are you now under the care of a physician?** ☐ Yes ☐ No

Current Physician

What condition is being treated?
Physician Name **Phone Number**
Address City State Zip

For Women

Are you pregnant? ☐ Yes ☐ No How many weeks?
Taking birth control pills or hormonal replacement? ☐ Yes ☐ No **Are you nursing?** ☐ Yes ☐ No

Have you had a serious illness, operation or been hospitalized in the past 5 years? ☐ Yes ☐ No
What was the illness or problem?
Are you taking or have you recently taken any prescription or over the counter medicine(s)? ☐ Yes ☐ No
Please list any medications (prescription or over the counter) you are taking:

Name		For what condition?		Dosage	
Name		For what condition?		Dosage	
Name		For what condition?		Dosage	
Name		For what condition?		Dosage	
Name		For what condition?		Dosage	

Do you need antibiotics prior to receiving dental care? ☐ Yes ☐ No Reason:

Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? ☐ Yes ☐ No

Date: Have you had any complications?

Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease? ☐ Yes ☐ No

Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? ☐ Yes ☐ No Date treatment began:

Do you use controlled substances (drugs)? ☐ Yes ☐ No

Do you use tobacco (smoking, snuff, chew, bidis)? ☐ Yes ☐ No Are you interested in quitting? ☐ Yes ☐ No

Do you drink alcoholic beverages? ☐ Yes ☐ No How much do you typically drink in a week?

Allergies

Are you allergic to or have you had a reaction to:

Local anesthetics	☐ Yes ☐ No	Details:	
Aspirin	☐ Yes ☐ No	Details:	
Penicillin or other antibiotics	☐ Yes ☐ No	Specify:	
Barbiturates, sedatives, or sleeping pills	☐ Yes ☐ No	Details:	
Sulfa drugs	☐ Yes ☐ No	Details:	
Codeine or other narcotics	☐ Yes ☐ No	Details:	
Metals	☐ Yes ☐ No	Details:	
Latex (rubber)	☐ Yes ☐ No	Details:	
Iodine	☐ Yes ☐ No	Details:	
Hay fever/seasonal	☐ Yes ☐ No	Details:	
Food	☐ Yes ☐ No	Details:	
Other			

Medical Conditions

Do you have, or have you had, any of the following diseases, medical conditions, or procedures?

AIDS / HIV Positive	☐ Yes ☐ No	**Drug Addiction**	☐ Yes ☐ No	**Low Blood Pressure**	☐ Yes ☐ No
Alzheimer's Disease	☐ Yes ☐ No	**Emphysema**	☐ Yes ☐ No	**Lung Disease**	☐ Yes ☐ No
Anaphylaxia	☐ Yes ☐ No	**Epilepsy or Seizures**	☐ Yes ☐ No	**Mitral Valve Prolapse**	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	**Excessive Thirst**	☐ Yes ☐ No	**Pain in Jaw Joints**	☐ Yes ☐ No
Angina	☐ Yes ☐ No	**Fainting Spells/Dizziness**	☐ Yes ☐ No	**Parathyroid Disease**	☐ Yes ☐ No
Arthritis/Gout	☐ Yes ☐ No	**Glaucoma**	☐ Yes ☐ No	**Psychiatric Care**	☐ Yes ☐ No
Artificial Heart Valve	☐ Yes ☐ No	**Heart Attack/Failure**	☐ Yes ☐ No	**Radiation treatment**	☐ Yes ☐ No
Artificial Joint	☐ Yes ☐ No	**Heart Murmur**	☐ Yes ☐ No	**Rheumatic Fever**	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	**Heart Pace Maker**	☐ Yes ☐ No	**Scarlet Fever**	☐ Yes ☐ No
Blood Disease	☐ Yes ☐ No	**Heart Trouble/Disease**	☐ Yes ☐ No	**Sickle Cell Disease**	☐ Yes ☐ No
Breathing Problems	☐ Yes ☐ No	**Hemophilia**	☐ Yes ☐ No	**Sinus Trouble**	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	**Hepatitis A, B or C**	☐ Yes ☐ No	**Stomach/Intestinal Disease**	☐ Yes ☐ No
Chest Pains	☐ Yes ☐ No	**High Blood Pressure**	☐ Yes ☐ No	**Stroke**	☐ Yes ☐ No
Cold Sores/Fever Blisters	☐ Yes ☐ No	**Irregular Heartbeat**	☐ Yes ☐ No	**Thyroid Disease**	☐ Yes ☐ No
Congenital Heart Disorder	☐ Yes ☐ No	**Kidney Problems**	☐ Yes ☐ No	**Tuberculosis**	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	**Leukemia**	☐ Yes ☐ No	**Tumors/Growths**	☐ Yes ☐ No

Do you have any disease, condition, or problem not listed above that you think we should know about? ☐ Yes ☐ No

Please explain:

Confirmation

I certify that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Patient Signature _____

OUR POLICIES

Welcome to PerioWest! We are happy to have you as our patient and we are committed to providing you with the best possible care. We will recommend treatment that is based on the most current standards. Before treatment is performed, we will discuss treatment and financial options. Our goal is to give you the information you need to make an informed decision on what care is best for you.

Initial Visit. All patients must undergo a Comprehensive Oral Exam. Dental x-rays will be required in order to provide a proper diagnosis of your condition. Please make sure your dentist has shared all current x-rays with our office, prior to your appointment. The fee for a Comprehensive Oral Exam (D0180) is $120 and if needed, a Complete X-ray Series (D0210) is $170, a Cone Beam CT Scan (D0363) is $180, of which payment is required, at the time of your first visit.

Dental Insurance. As a courtesy to our insured patients, we will submit claims and pre-treatment estimates per patient's request after your initial exam. However pre-treatment estimate from your insurance company is **not** a guarantee of coverage. The guarantor is personally liable for all balances not covered by dental insurance. It is patient's responsibility to understand their insurance benefits. PerioWest is a provider for a Delta Dental PPO & Premier (excluding Group #216). If we are unable to verify your insurance information during your appointment, you will be expected to pay for services rendered. Please be aware that we cannot submit any medical insurance claims. Should you decide to contact your medical insurance about possible medical benefits, we will release your dental records to you. Please note that all correspondence with medical insurance is the patient's responsibility.

Payments. Patients are expected to pay for our services at the time they are rendered, unless other payment arrangements were made with a financial coordinator. For in-network insured patients, estimated out of pocket fee is collected on the date of service. For out of network patients service fee is collected in full, dental claims will be submitted on your behalf and a payment will be instructed to be sent directly to you. For your convenience we accept cash, check, Visa, MasterCard and Discover. The State of Minnesota requires a 2% Healthcare Tax to be added to all treatment.

Past-Due Accounts. Finance charges will be added on accounts 60 days from the date of the initial billing. We charge a 1.5% service charge or a $3.50 handling fee (whichever is greater) on all past due accounts until they are paid in full. If the balance is still unpaid after 90 days, the account will be referred to collection agency and any collections costs (25% of the balance) and/or legal costs 40% will be added to your balance and will become patient's responsibility. For any returned "non-sufficient fund" checks, a bank fee of $35.00 will be assessed.

Missed Appointments. Your appointment time is reserved specifically to meet your dental needs. Consequently, we request advanced notification for changes and cancellations. To reschedule or cancel your appointment, please notify us at least three (3) business days for any procedure and at least two (2) business days for a non-procedural or hygiene appointment. Patients 15 minutes late for a scheduled appointment may be considered an appointment failure, unless there are pressing circumstances. Failure to give proper cancelation notice will result in a: 1) loss of your deposit ($1,000 maximum) for any procedure; or a 2) $50 fee for non-procedural or hygiene appointment.

Authorization to Release Information and Assignment of Benefits. I assign directly to PerioWest all dental insurance benefits, (if applicable), otherwise payable to me for services rendered. I hereby authorize the doctor and/or his staff to release all necessary personal information to my insurance company in order to secure the payment of benefits.

By signing below, I verify that I completely understand, agree, and accept the policies outlined above. I further acknowledge that I am responsible for all charges incurred, including those not covered by my dental insurance (if applicable). I agree to pay for the services rendered. If my insurance company denies payment, I agree to be personally responsible for payment.

PerioWest reserves the right to update and make changes the above-stated office policies at any time without prior notification.

Name: _____

Signature: _____ Date: _____

ACKNOWLEDGMENT AND CONSENT FOR USE OF NOTICE OF PRIVACY PRACTICES & DISCLOSURE OF HEALTH INFORMATION

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY!

NOTICE OF PRIVACY PRACTICES: You have a right to read our Notice of Privacy Practices before deciding whether or not to sign this Consent. Your Notice of Privacy provides a description of treatment, payment activities, and healthcare operations, of the uses and disclosures you may make of my protected health information, and of other important matters about my protected health information. A copy of this Notice accompanies this Consent.

PURPOSE OF CONSENT: By signing this form, you will consent to our use and disclosure of your protected health information to carry out Treatment, Payment, Activities, Healthcare Operations, Subpoenas, Immunization Information, Notice of Privacy Practices, Minnesota Healthcare Bill of Rights, Workers Compensation, Patient Access, Minors, Provider to Provider, Communication via email, text, USPS, Phone.

PURPOSE OF ACKNOWLEDGEMENT: By signing this form you acknowledge you had the opportunity to read our Notice of Privacy Act, effective date of 04/06/16. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting: Mariana Binus at 7810 Terrey Pine Court, Eden Prairie, Minnesota, 952-567-7858.

RIGHT TO REVOKE

You have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if this Consent is revoked.

I, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Name: _____

Signature: _____ Date: _____

If this consent is signed by a Personal Representative on behalf of the patient, complete the following:

Personal Representative's Name: _____Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT