UELLER Implants & Periodontics

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Board Certified in Periodontology and Dental Implant Surgery

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PATIENT INFORMATION

Name: ______________________________ Age: ________ Date of Birth: ______________
Mailing Address: ____________________________ City: __________ State: ______ Zip: __________
Home Phone: _______________ Cell Phone: _______________ Email: ________________________
Occupation: ____________________ Employer: ___________________ Phone: ____________________
Referred By: _____________________________ General Dentist: _______________________________
Emergency Contact: ___________________ Phone: ________________ Relationship to patient: _______
Spouse/Partner: ____________________ Date of Birth: ______________ Phone: __________________
Occupation: ___________________________________ Employer: ______________________________

INSURANCE INFORMATION

Primary Dental Insurance: ____________________
Insurance Co. Phone: ________________________
Subscriber/Employee: ________________________
Subscriber ID# _________________ DOB: _______
Employer: _________________________________
Group #: __________________________________

Secondary Dental Insurance: __________________
Insurance Co. Phone: ________________________
Subscriber/Employee: ________________________
Subscriber ID# _________________ DOB: _______
Employer: _________________________________
Group #: __________________________________

AUTHORIZATION

I authorize payment of insurance benefits to be paid to the provider.

I understand I am responsible for all costs of treatment and acknowledge that finance charges will accrue on any unpaid balance after 90 days.

I authorize the provider to administer medications and/or perform diagnostic and therapeutic procedures as necessary.

If you unable to keep your appointment, please notify us at least 48 hours in advance. Appointments cancelled or changed with less than 48-hour notice will be charged a $100.00 cancellation fee.

The information on this form is correct to the best of my knowledge.

Signature of Responsible Party: ____ Date: ________________

Relationship to Patient: ☐ Self OR ☐ Legal Guardian

MEDICAL INFORMATION

Primary Physician: ____ Phone: ___________________________

Other Physician: ___________________ Specialty: ______________ Phone: ___________________________

Other Physician: ___________________ Specialty: ______________ Phone: ___________________________

Are you currently under a doctor's care? ______ If yes, please explain: ________________________________

Have you been hospitalized or had surgery in the last 5 years? ______ If yes, please explain: _______________

Women: Are you pregnant? __________Due Date: __________Are you Nursing: _________

Do you smoke/Chew Tobacco?	☐ Yes	☐ No	Amount/Day: ___________ How long? ____________
Do you use alcohol?	☐ Yes	☐ No	Drinks/Week: ________________________________

Have you ever had an unfavorable reaction following dental treatment? __________

If yes, please explain: ____

Has a physician recommended antibiotic premedication for dental treatments? ____________

Why was premedication recommended? ☐ Joint replacement ☐ Medical Condition ☐ Heart Condition

What medication was recommended? ____________________________________

Are you sensitive or allergic to:		
Antibiotics: ☐ Amoxicillin ☐ Erythromycin ☐ Penicillin ☐ Sulfa Drugs ☐ Tetracycline	Other Allergies: ☐ Codeine ☐ Metals ☐ Latex ☐ Sedatives ☐ Bee Pollen	Dental Anesthetics: ☐ Topical (Numbing) ☐ Local Anesthetic (Numbing Injection) OTHER: ________________________

Have you taken in the past 12 years, or are you currently taking, any bisphosphonate medications? _________

Please indicate medication: ☐ Actonel ☐ Fosamax ☐ Zometa ☐ Other _____________________

Haw was medication administered? ☐ Intravenous OR ☐ Orally

How long did you take medication? ___________________

Are you taking any prescription/recreational medications, supplements, or vitamins at this time? ___________

Current medications you are taking:

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Patient Name: ____ Date: ________________

MEDICAL/DENTAL CONDITIONS

Do you have or have you experienced any of the following? Please check all that apply.

☐ AIDS/HIV	☐ Epilepsy or Seizures	☐ Nervousness
☐ Abnormal Bleeding	☐ Excessive Thirst	☐ Neurological Disorders
☐ Alcohol Addiction	☐ Fainting or Dizzy Spells	☐ Organ Transplant
☐ Alzheimer's or Dementia	☐ Fibromyalgia	☐ Osteoporosis
☐ Anemia	☐ Glaucoma	☐ Pacemaker
☐Arthritis/Gout	☐ Hay Fever	Date Placed: ______________
☐ Artificial Joints/Pins	☐ Headaches	Type: ____________________
Joint Location: _____________	☐ Hearing Problems	☐ Parkinson's
Date Placed: ______________	☐ Heart Attack	☐ Persistent Cough
☐ Artificial Heart Valve	Date: ______________	☐ Radiation Therapy
☐ Asthma	☐ Heart Disease	☐ Recent Weight Loss/Gain
☐ Bladder Trouble	☐ Heart Murmur	☐ Rheumatic Fever
☐ Blood Disease	☐ Heart Surgery	☐ Rheumatism
☐ Blood Thinners/Anticoagulants	Type of surgery: ___________________	☐ Scarlet Fever
☐ Blood Transfusion	☐ Heart Trouble	☐ Seizure Disorder
☐ Cancer/Tumors	☐ Hemophilia	☐ Sexually Transmitted Disease
List Type: _________________	☐ Hepatitis A	Type: ____________________
☐ Chemotherapy	☐ Hepatitis B	☐ Shingles
☐ Chest Pains	☐ Hepatitis C	☐ Shortness of Breath
☐ Chicken Pox	☐ Herpes	☐ Sickle Cell Disease
☐ Cold Sores	☐ High Blood Pressure	☐ Sinus Trouble
☐ Colitis	☐ Kidney Disease	☐ Sleeping Disorder/CPAP
☐ Congenital Heart Defect	☐ Limited Mobility	☐ Stroke/CVA
☐ Diabetes	Requiring assistance?	☐ Steroid Therapy
Type: ☐ I OR ☐ II	☐ Liver Disease	☐ Swelling of feet/ankles
Recent HbA1c Value: _________	☐ Low Blood Pressure	☐ Thyroid Disease
☐ Hypoglycemic	☐ Lung Disease	☐ Tonsilitis
☐ Difficulty Breathing	☐ Lupus	☐ Tuberculosis
☐ Drug Addiction	☐ Mental or Psychiatric Care	☐ Ulcers/Acid Reflux
☐ Emphysema/COPD	☐ Mitral Valve Prolapse	☐ Other

Please list any serious medical conditions not indicated above that you have experienced in the last 5 years:

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Pharmacy: ________________________________ Street: ___________________ City: ________________

Signature: ____ Date: __________________