Hurm Family Dentistry

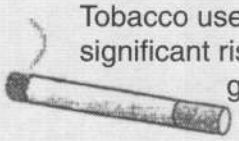
for a better looking smile...

Periodontal Risk Assessment Questionnaire

Name _____ Date _____

Tobacco Use

Tobacco use is the most significant risk ractor for gum disease.



Blood Sugar

Diabetes

Gum disease is a common complication of diabetes. Untreated gum disease makes it harder for patients with diabetes to control their blood sugar.

Heart Attack / Stroke

Untreated gum disease may increase your risk for heart attack or stroke.

Medications

A side effect of some medications can cause changes in your gums..

Family History / Genetics

The tendency for gum disease to develop can be inherited.

Do you now or have you ever used the following:

	Amounts per day	*Used for how many years*	*If you quit, list what year*
❑ Cigarette	_____	_____	_____
❑ Cigar	_____	_____	_____
❑ Pipe	_____	_____	_____
❑ Chewing	_____	_____	_____

IF YOU ARE A PATIENT WHO HAS DIABETES:

Is your diabetes under control? ❑ Yes ❑ No

Are you prone to diabetic complications? ❑ Yes ❑ No

How do you monitor your blood sugar? _____

Who is your physician for diabetes? _____

IF YOU ARE NOT A PATIENT WHO HAS DIABETES:

Any family history of diabetes? ❑ Yes ❑ No

Have you had any of these warning signs of diabetes?

❑ frequent urination ❑ excessive thirst

❑ excessive hunger ❑ weakness and fatigue

❑ slow healing of cuts ❑ unexplained weight loss

Do you have any risk factors for heart disease or stroke?

❑ Family history of heart disease ❑ Tobacco use ❑ Obesity

❑ High cholesterol ❑ High blood pressure

If you have any of these other risk factors it is especially important for you to always keep your gums as healthy as possible.

Are you taking or have you ever taken any of the following medications:

❑ Antiseizure medications (such as Dilantin®, Tegretol®, Phenobarbital, etc.)

❑ Yes ❑ No

If you answered yes, are you still taking the anti-seizure medication?

❑ Yes ❑ No

Other Medication: _____

❑ Calcium Channel Blocker blood pressure medication. (such as Procardia®, Cardizem®, Norvasc®, Verapamil®, etc.)

Other: _____

❑ Immunosuppressant therapy (such as Prednisone, Azathioprine, Cyclosporins, Corticosteroids (Asthma-Inhalers), etc.)

Other: _____

Is there an immediate family member(s) who currently has or had gum problems in the past? (e.g. your mother, father, or siblings):

❑ Yes ❑ No

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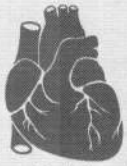

Heart Murmur, Artificial joint prosthesis

If you have even the slightest amount of gum inflammation, bacteria from the mouth can enter the bloodstream and may cause a serious infection of the heart or joints.

Do you have a heart murmur or artificial joint?

❑ Yes ❑ No

If so, does your physician recommend antibiotics prior to dental visits?

❑ Yes ❑ No

Name of physician? _____

If you answered yes, it is especially important to always keep your gums as healthy and inflammation-free as possible to reduce the chance of bacterial infection originating from the mouth.

Females

Females can be at increased risk for gum disease at different points in their lives.

The following can adversely affect your gums. Please check all that apply:

❑ Pregnant ❑ Nursing ❑ Menopause

❑ Taking birth control pills

❑ Infrequent care during previous pregnancies

Women

Women with osteoporosis have a greater risk for periodontal bone loss.

Females:
Do you take any of the following:

❑ Estrogen Replacement Therapy/Hormone Replacement Therapy (such as Prempro®, Premarin®, Premphase®, Fosamax®, Actonel®, Evista®, Fortéo®, etc.)

Other: _____

Stress

High levels of stress can reduce your body's immune defense.

Are you under a lot of stress?

❑ Yes ❑ No

Nutrition

Your diet has the potential to affect your periodontal health.

Do you find it difficult to maintain a well-balanced diet?

❑ Yes ❑ No

All patients please complete the following:

Have you noticed any of the following signs of gum disease?

❑ Bleeding gums during toothbrushing
❑ Red, swollen or tender gums
❑ Gums that have pulled away from the teeth
❑ Persistent bad breath
❑ Pus between the teeth and gums
❑ Loose or separating teeth
❑ Change in the way your teeth fit together
❑ Food catching between teeth

Is it important to keep your teeth for as long as possible? ❑ Yes ❑ Not really

If you have missing teeth, why have you not had them replaced? _____

Do you like the appearance of your smile? ❑ Yes ❑ No

Do you like the color of your teeth? ❑ Yes ❑ No

Do your teeth keep you from eating any specific food? ❑ Yes ❑ No

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- ○ Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- ○ Obtain payment from third-party payers
- ○ Conduct normal healthcare operations such as quality assessments and physician certifications

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name _____

Relationship to Patient _____

Signature _____

Date _____

Office Use Only

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date _____ Initials _____
Reason:

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Financial Policy and Patient Responsibility

Effective June 1, 2009

Welcome to Hurm Family Dentistry,

In order to provide the best possible dental care and to help clarify often confusing dental insurance policies and reimbursement, we have established the following policy.

If you have any changes in your coverage, please let us know at least 24 hours prior to your appointment by calling the office. We will need a copy of your insurance card at that time. If you choose this office for services and you have an insurance company that we do not have a contractual agreement with, you will be responsible for payment of the charges incurred at the time of service. Please contact your insurance company to assure you have coverage with this office for certain services, for example crowns or dentures, to ensure that you have no waiting period.

At the time of your appointment, we will do our best to ***estimate*** your responsibility for the services that we complete. Please understand that this is not an exact amount and may vary once we receive payment from your insurance company. We require payment ***at the time of service*** for this amount.

Good dental care and a positive doctor-patient relationship are dependent upon consistent consultation and treatment. This cannot be accomplished with frequent missed appointments. If it is necessary to cancel your scheduled appointment, we require that you call by 10 am one (1) working day in advance. Cancellations after 10 am one (1) working day in advance will be considered a missed appointment and will result in a fee of $55.00. We do realize that on rare occasion emergencies may take place and we will address these situations with you at that time. Additionally, we reserve the right to terminate our relationship with you after three (3) or more occurrences.

Again, understand that you are financially responsible for all charges incurred in our office, including fees that are acquired for missed appointments and cancellations without the appropriate notification and all balances that your insurance company does not cover.

If we do not receive payment in full within ninety (90) days and you have not made arrangements with our business office, your account will be considered for collections. If your account is placed in collections, you will be responsible for the collection fees including but not limited to agency fees, attorney fees and court costs.

We gladly accept Cash, Check, Visa and Mastercard. CareCredit, our in house financing option, is also available and approval takes just a few minutes. If your account is not paid in full within 30 days from the date of service, a 12% annual finance charge will be assessed on any outstanding balance.

I acknowledge that I have read, understand, and agree with the above office policies.

Signature **Date**

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Patient's name _____

This office is an amalgam-free office, which means we only provide composite fillings for your teeth.

However, your insurance company may require you to pay for the difference between composite (tooth colored) and amalgam (silver) fillings.

I accept the additional financial responsibility for composite (tooth colored) fillings.

Patient's/Guardian's signature: _____

Date: _____

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MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ○ Yes ○ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ○ Yes ○ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ○ Yes ○ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ○ Yes ○ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ○ Yes ○ No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ○ Yes ○ No _____

Are you on a special diet? ○ Yes ○ No
Do you use tobacco? ○ Yes ○ No
Do you use controlled substances? ○ Yes ○ No

Women: Are you
Pregnant/Trying to get pregnant? ○ Yes ○ No Taking oral contraceptives? ○ Yes ○ No Nursing? ○ Yes ○ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs

☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ○ Yes ○ No	Cortisone Medicine ○ Yes ○ No	Hemophilia ○ Yes ○ No	Radiation Treatments ○ Yes ○ No
Alzheimer's Disease ○ Yes ○ No	Diabetes ○ Yes ○ No	Hepatitis A ○ Yes ○ No	Recent Weight Loss ○ Yes ○ No
Anaphylaxis ○ Yes ○ No	Drug Addiction ○ Yes ○ No	Hepatitis B or C ○ Yes ○ No	Renal Dialysis ○ Yes ○ No
Anemia ○ Yes ○ No	Easily Winded ○ Yes ○ No	Herpes ○ Yes ○ No	Rheumatic Fever ○ Yes ○ No
Angina ○ Yes ○ No	Emphysema ○ Yes ○ No	High Blood Pressure ○ Yes ○ No	Rheumatism ○ Yes ○ No
Arthritis/Gout ○ Yes ○ No	Epilepsy or Seizures ○ Yes ○ No	High Cholesterol ○ Yes ○ No	Scarlet Fever ○ Yes ○ No
Artificial Heart Valve ○ Yes ○ No	Excessive Bleeding ○ Yes ○ No	Hives or Rash ○ Yes ○ No	Shingles ○ Yes ○ No
Artificial Joint ○ Yes ○ No	Excessive Thirst ○ Yes ○ No	Hypoglycemia ○ Yes ○ No	Sickle Cell Disease ○ Yes ○ No
Asthma ○ Yes ○ No	Fainting Spells/Dizziness ○ Yes ○ No	Irregular Heartbeat ○ Yes ○ No	Sinus Trouble ○ Yes ○ No
Blood Disease ○ Yes ○ No	Frequent Cough ○ Yes ○ No	Kidney Problems ○ Yes ○ No	Spina Bifida ○ Yes ○ No
Blood Transfusion ○ Yes ○ No	Frequent Diarrhea ○ Yes ○ No	Leukemia ○ Yes ○ No	Stomach/Intestinal Disease ○ Yes ○ No
Breathing Problem ○ Yes ○ No	Frequent Headaches ○ Yes ○ No	Liver Disease ○ Yes ○ No	Stroke ○ Yes ○ No
Bruise Easily ○ Yes ○ No	Genital Herpes ○ Yes ○ No	Low Blood Pressure ○ Yes ○ No	Swelling of Limbs ○ Yes ○ No
Cancer ○ Yes ○ No	Glaucoma ○ Yes ○ No	Lung Disease ○ Yes ○ No	Thyroid Disease ○ Yes ○ No
Chemotherapy ○ Yes ○ No	Hay Fever ○ Yes ○ No	Mitral Valve Prolapse ○ Yes ○ No	Tonsillitis ○ Yes ○ No
Chest Pains ○ Yes ○ No	Heart Attack/Failure ○ Yes ○ No	Osteoporosis ○ Yes ○ No	Tuberculosis ○ Yes ○ No
Cold Sores/Fever Blisters ○ Yes ○ No	Heart Murmur ○ Yes ○ No	Pain in Jaw Joints ○ Yes ○ No	Tumors or Growths ○ Yes ○ No
Congenital Heart Disorder ○ Yes ○ No	Heart Pacemaker ○ Yes ○ No	Parathyroid Disease ○ Yes ○ No	Ulcers ○ Yes ○ No
Convulsions ○ Yes ○ No	Heart Trouble/Disease ○ Yes ○ No	Psychiatric Care ○ Yes ○ No	Venereal Disease ○ Yes ○ No
			Yellow Jaundice ○ Yes ○ No

Have you ever had any serious illness not listed above? ○ Yes ○ No

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

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PATIENT REGISTRATION

ID: _____ Chart ID: _____

First Name: _____ Last Name: _____ Middle Initial: ____

Patient Is: ☐ Policy Holder ☐ Responsible Party

Preferred Name: _____

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: ____

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext.: _____ Cellular: _____

Birth Date: _____ Soc. Sec.: _____ Drivers Lic.: _____

○ Responsible Party is also a Policy Holder for Patient ○ Primary Insurance Policy Holder ○ Secondary Insurance Policy Holder

Patient Information

Address: _____ Address 2: _____

City: _____ State / Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext.: _____ Cellular: _____

Sex: ○ Male ○ Female Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Birth Date: _____ Age: _____ Soc. Sec.: _____ Drivers Lic.: _____

E-mail: _____ ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ○ Full Time ○ Part Time ○ Retired

Student Status: ○ Full Time ○ Part Time

Medicaid ID: _____ Pref. Dentist: _____

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg.: _____

Section 3

Pano or FMX 1x/3 yrs: _____

Pano or FMX 1x/5 yrs: _____

BWX 1x/yr: _____

Fluoride 1x/yr under: _____

Fluoride 2x/yr under: _____

Missing tooth clause: _____

Composite downgraded: _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. Sec.: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City, State, Zip: _____ City, State, Zip: _____

Rem. Benefits: _____.00 Rem. Deduct.: _____.00

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. Sec.: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City, State, Zip: _____ City, State, Zip: _____

Rem. Benefits: _____.00 Rem. Deduct.: _____.00