Anderson Periodontal Wellness
PATIENT REGISTRATION

PATIENT INFORMATION

First Name _____ Last Name _____ Middle Name _____

Address _____ Address 2 _____

City, State, Zip _____ Date of Birth _____ Soc Sec # _____

Phone # _____ Cell # _____

Email Address _____ ☐ I would like to receive emailed correspondence for this office.

Sex Female ☐ Male ☐ Marital Status Single ☐ Married ☐ Divorced ☐ Widowed ☐

Emergency Contact _____ Phone # _____

PRIMARY DENTAL INSURANCE INFORMATION

Name of Subscriber _____ Relationship Self ☐ Spouse ☐ Child ☐

Employer _____ Insurance _____

Address _____ Address _____

Address 2 _____ Address 2 _____

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

Subscriber Birthdate _____ Subscriber Soc Sec # _____

SECONDARY DENTAL INSURANCE INFORMATION

Name of Subscriber _____ Relationship Self ☐ Spouse ☐ Child ☐

Employer _____ Insurance _____

Address _____ Address _____

Address 2 _____ Address 2 _____

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

Subscriber Birthdate _____ Subscriber Soc Sec # _____

MEDICAL HISTORY

Patient Name: _____

Name of Physician _____

What is your estimate of your general health? _____

Are you currently being treated for any illness ? _____

Any changes in your health in the last 24 hours (fever, chills, diarrhea)? _____

Were you recently hospitalized for illness or injury? _____ ☐ ☐

DO YOU HAVE or HAVE YOU EVER HAD:

		Yes	No
1	Allergies to any medications? _____ _____ _____		
2	Do you take blood thinners?	☐	☐
	If so, What is your INR or bleeding time? _____		
3	Do you Smoke? If so how long and how much? _____	☐	☐
4	Do you have Diabetes? What is your A1C level? _____	☐	☐
5	Heart problems, or cardiac stent w/in 6 months	☐	☐
6	History of infective endocarditis	☐	☐
7	Artificial heart valve, repaired heart defect (PFO)	☐	☐
8	Pacemaker or implantable defibrillator	☐	☐
9	Artificial prosthesis (heart valve or joints)	☐	☐
10	Rheumatic or scarlet fever	☐	☐
11	High or Low blood pressure	☐	☐
12	Stroke (are you taking blood thinners)	☐	☐
13	Anemia or other blood disorder	☐	☐
14	Prolonged bleeding	☐	☐
15	Emphysema, shortness of breath, sarcoidosis	☐	☐
16	Tuberculosis, measles, chicken pox	☐	☐
17	Asthma	☐	☐
18	Breathing or sleep problems	☐	☐
19	Kidney or Liver Disease _____	☐	☐
20	Jaundice	☐	☐
21	Thyroid, parathyroid, or calcium deficiency	☐	☐
22	Hormone deficiency	☐	☐
23	High cholesterol or taking statin drugs	☐	☐
24	Stomach or duodenal ulcer	☐	☐
25	Digestive disorder (celiac disease, gastric reflux)	☐	☐
26	Frequent headaches	☐	☐
27	Arthritis, rheumatoid arthritis, lupus	☐	☐
28	Head or neck injuries	☐	☐
29	Epilepsy, convulsions (seizures)	☐	☐
30	Neurologic disorders ADD/ADHD	☐	☐
31	Osteoporosis/Osteopenia	☐	☐
32	Cancer	☐	☐
33	Radiation therapy	☐	☐
34	Chemotherapy, immunosuppressive	☐	☐
35	Bisphosphonates/RANK-L inhibitors?	☐	☐
36	Psychiatric treatment	☐	☐
37	Anti-depressant medication	☐	☐
38	Alcohol/Street drugs?	☐	☐
	Frequency? _____		
39	Viral Infections and cold sores	☐	☐
40	Any lumps or swelling in the mouth	☐	☐
41	Hives, skin rash, hay fever	☐	☐
42	STI/STD	☐	☐
43	Hepatitis (type _____)	☐	☐
44	HIV/AIDS	☐	☐
45	Medications for weight/dietary	☐	☐
46	Women - Taking Birth Control/Pregnant	☐	☐
47	Men - Prostate disorders	☐	☐

List all medication, supplements, and or vitamins taken in the last two years.

Drug	Purpose	Drug	Purpose

Please advise our office of any changes in your medical or dental history or changes with your medications.

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Anderson Periodontal Wellness
DENTAL HISTORY

Patient Name _____

General Dentist _____ Referred by _____

Date of most recent dental exam _____ Date of most recent cleaning _____

I routinely see my dentist every: ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely (circle one)

Date and description of most recent treatment (other than cleaning) _____

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

PERSONAL HISTORY	Yes	No
1 Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) _____	☐	☐
2 Have you had an unfavorable dental experience? _____	☐	☐
3 Have you ever had complications from past dental treatment? _____	☐	☐
4 Did you ever have braces, orthodontic treatment or had your bite adjusted? _____	☐	☐

GUM AND BONE	Yes	No
5 Do your gums bleed or are they painful when brushing or flossing? _____	☐	☐
6 Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____	☐	☐
7 Have you ever noticed an unpleasant taste or odor in your mouth? _____	☐	☐
8 Is there anyone with a history of periodontal disease in your family? _____	☐	☐
9 Have you ever experienced gum recession? _____	☐	☐

TOOTH STRUCTURE	Yes	No
10 Does the of saliva in your mouth seem too little? Do you have difficulty swallowing any food? _____	☐	☐
11 Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? _____	☐	☐
12 Do you have grooves or notches on your teeth near the gum line? _____	☐	☐
13 Do you frequently get food caught between any teeth? _____	☐	☐

BITE AND JAW JOINT	Yes	No
14 Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____	☐	☐
15 Do you feel like your lower jaw is being pushed back when you bite your teeth together? _____	☐	☐
16 Have your teeth changed in the last 5 years, become shorter, thinner or worn? _____	☐	☐
17 Are your teeth crowding or developing spaces? _____	☐	☐
18 Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____	☐	☐
19 Do you clench your teeth in the daytime or make them sore? _____	☐	☐
20 Do you have any problems with sleep or wake up with an awareness of your teeth? _____	☐	☐
21 Do you wear or have you ever worn a bite appliance? _____	☐	☐

SMILE CHARACTERISTICS	Yes	No
22 Do you have an uneven smile, too much gum, or small teeth? _____	☐	☐
23 Is there anything about the appearance of your teeth that you would like to change? _____	☐	☐
24 Have you felt uncomfortable or self conscious about the appearance of your teeth and gums? _____	☐	☐
25 Do you have any other concerns? _____	☐	☐

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

ANDERSON
PERIODONTAL WELLNESS

Dr. Lauren Anderson Welcomes You!

Privacy Policy
Our office is fully committed to compliance with HIPAA guidelines by providing appropriate security and privacy for our patient's records, providing our patients with proper access to their medical records, and maintaining information and billing processes in compliance with national HIPAA standards. Please see the complete copy of Anderson Periodontal Wellness, PLLC Notice of Privacy Practices for further details.

Financial Policy
Financial arrangements will be agreed upon after your initial exam and prior to comprehensive treatment initiation. Your dental insurance is a contract between you and your insurance carrier. We cooperate fully in filing your claims and aiding you with your insurance carrier, however, you are ultimately financially responsible for your account. You will be liable for services not covered by your insurance provider, services deemed ineligible by your carrier and services exceeding your insurance maximum.

Cancellation Policy
We require a 48 hour notice for cancellations. If canceling less than 48 hours before the appointment, there will be a charge. The amount of the charge will be 25% of the cost of the treatment scheduled. Also, please note that if you arrive late for an appointment, we may consider that a missed appointment.

Release Policy
I authorize Anderson Periodontal Wellness to perform diagnostic procedures and treatment as necessary for proper dental care. Diagnostic procedures may include photographs, which may be later used for lecture or teaching purposes. I authorize release of any information concerning my health care, advice, and treatment only to another dentist or physician. By signing this statement, I revoke all previous agreements to the contrary and I attest to the accuracy of information on this page.

_____ _____
Signature of Patient or Responsible Party Date

Lauren E. Anderson DDS, MS • Diplomate American Academy of Periodontology

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www.AndersonPeriodontal.com • info@andersonperiodontal.com

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Anderson Periodontal Wellness PLLC to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). The Notice of Privacy Practices provided by Anderson Periodontal Wellness PLLC describes such uses and disclosures more completely.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Anderson Periodontal Wellness PLLC reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the office.

With this consent, Anderson Periodontal Wellness PLLC may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Anderson Periodontal Wellness PLLC may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With this consent, Anderson Periodontal Wellness PLLC may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Anderson Periodontal Wellness PLLC restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Anderson Periodontal Wellness PLLC to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Anderson Periodontal Wellness PLLC may decline to provide treatment to me.

_____ _____

Signature of Patient or Legal Guardian Date

_____

Print Patient’s Name

Acknowledgement of Receipt of Notice of Privacy Policy

I acknowledge that I received a copy and read through the Consent for Use and Disclosure of Protected Health Information and have the opportunity to review the Notice of Privacy Practices for Anderson Periodontal Wellness PLLC.

Patient Name: _____ Date: _____

Signature: _____

I authorize and approve the following individuals can be informed of my periodontal status and/or treatment rendered:

I _____, will allow Anderson Periodontal Wellness PLLC to discuss my periodontal treatment or diagnosis with the following individuals listed below. (An example would be a spouse or significant other, a family member or friend who may be driving you to and from the treatment following sedation).

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____