Oakland Periodontal Associates

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Specializing in Periodontics and the placement of dental implants

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Date______________

General Information

In order for us to render proper periodontal services for you, please complete the following questions in their entirety. All information is kept strictly confidential. Thank you.

Name:_______________________________Birthdate_________________Sex_______M_______F
Address_____________________________________Home Phone_______________________
Cell Phone________________________
City___________________________________State_____________Zip__________________
Social Security #____
Referring Dentist Name:____
Employer:_____________________________Occupation______________________________
Address___________________________Business Phone_____________________________
City___________________________________State______________Zip_________________

Insurance policyholder (Self, Spouse, or Parent) Name & Social Security/ID number:
____
Insurance Co. Name:____
Address____
City_________________________________State________________Zip________________
Phone___________________________________Group______________________________

Spouse Name:____________________________Social Security #________________________
Employer_____________________________Occupation______________________________
Address________________________________Business Phone___________________________
City__________________________________State________________Zip_________________

Spouse Dental Ins. Co. Name:________________________________Group #________________
Address____Phone________________________
City_________________________________State____________________Zip______________

Health History

When was the last time your teeth were cleaned?____

Has there been any problem with your health in the last 5 years? If so, for what?_________________

____

Are you under the care of a doctor now? Y_____________________N____________________________

If yes, for what?____

Do you take any medications regularly? (Please include drugs such as aspirin, vitamins, etc.)________

____

____

Are you allergic or sensitive to any of the following:

Penicillin Y_________N_________

Novacaine Y_________N_________

Codeine Y_________N_________

Latex (Gloves) Y_________N_________

Asprin Y_________N_________

Any others? Please list____

Do you have or have had any of the following:

Rheumatic fever..Y___________N___________

Stroke..Y___________N___________

High blood pressure..Y___________N___________

Heart Murmur...Y___________N___________

Mitral Valve Prolapse..Y___________N___________

Anemia..Y___________N___________

Asthma..Y___________N___________

Diabetes..Y___________N___________

Positive test for Aids Virus...Y___________N___________

Positive Test for Veneral disease...Y___________N___________

Abnormal bleeding...Y___________N___________

Epilepsy...Y___________N___________

Orthopedic joint replacement..Y___________N___________

Organ transplant...Y___________N___________

Radiation treatment for a tumor or growth................................Y___________N___________

Women: Are you pregnant?...Y___________N___________

Tuberculosis...Y___________N___________

Hepatitis (Jaundice) liver disease...Y___________N___________

Thyroid...Y___________N___________

Do you get out of breath easily?..Y___________N___________

Please list any other health condition/problem we should be aware of____________________

____

Name of your physician:____

I authorize the release of information related to this claim and authorize payment to the dentist of the group insurance benefits otherwise payable to me. I understand I am responsible for all costs of the dental treatment.

**Signed____Date_________________________________