Carter Periodontics & Implant Dentistry

2283 Raleigh Court • Clarksville, TN 37043 • (931) 614–6603

Patient Information

Please Print

Patient Name:_____ Date:_____

Birth Date:_____ Social Security #: _____ Sex: M F

Address:_____ Zip:_____ Home #: (_____)_____

Employer Name:_____ Address:_____

Cell #: (_____)_____ Ext:_____ Work #: (_____) _____ Home Phone: (____)_____

E-Mail :_____ Emergency Contact:_____ Relationship:_____

Spouse or Responsible Party Information (if other than Patient)

Name:_____ **Birth Date:** _____ **SS#** _____

Address:_____ Zip:_____

Home #:(_____)_____ Cell #: (_____)_____ Work#:(_____)_____

Dental Insurance Information

Primary Insurance

Name of insured:_____ Insured's Birth Date:_____

ID or SS#:_____ Group#:_____ Home #: (_____)_____

Insured's Address:_____ZIP_____

Employer's Address:_____ Work #: (____) _____ Ext: _____

Insured's Employer Name:_____

Patient's Relationship to insured: Self Spouse Child Other: _____

Insurance Plan Name:_____ Phone #: (_____)_____

Insurance Address:_____

Patient Dental History

Referring Dentist:_____

Do You Pre-Medicate Before Appointments?: Yes or No

If yes, list reason_____

Date & location of last Dental Hygiene Appointment: _____

Have you had Scaling and Root planning in the past?: Yes or No

Are you on a Periodontal Maintenance Schedule?: Yes or No?

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Patient Medical History

Medical Physician:_____ Office #(_____) _____ Date of Last Physical:_____

Address:_____

1. Are you under medical treatment now? Yes No
2. Have you ever been hospitalized for any surgical operations or serious illness within the last 5 years? if yes, explain, _____ Yes No

3. Are you taking any medication(s) including non-prescription medicine?
o Yes o No If yes, what medication(s) are you taking? _____
_____
_____
_____
_____

4. Do you use tobacco? Yes No
5. Do you use any illegal drugs? Yes No
6. Are you wearing contact lenses? Yes No
7. Are you taking blood thinners? Yes No
8. Do you take aspirin daily? Yes No

9. Are you allergic to or have any reactions to the following:
o Local Anesthetics (e.g. Novocaine)
o Penicillin (Amoxicillin)
o Other Antibiotics
o Sulfa Drugs
o Barbiturates
o Sedatives
o Iodine
o Codeine
o Ultram (Tramadol)
o Any Metal (e.g. Nickel, Mercury, etc.)
o Latex/Rubber
o Other (please list)_____

10. Women Only:
Are you pregnant, or think you may be? Yes No
Are you nursing? Yes No
Are you taking oral contraceptives? Yes No

11. **Do you have, or have you ever had, any of the following? (Check the box if it applies to you)**

O Abnormal Bleeding	O Diabetes, Insulin Dependent Yes /No	O High Blood Pressure	O Sinus Problems
O Alcohol Abuse	O Difficulty Breathing	O Kidney Problems/Disease	O Stroke
O Allergies	O Drug Abuse	O Liver Disease	O Thyroid Problems
O Anemia	O Emphysema/COPD	O Low Blood Pressure	O Tuberculosis
O Angina/ Chest Pains	O Epilepsy/Convulsions	O Mitral Valve Prolapse	O Ulcers
O Arthritis	O Fainting Spells	O Pace Maker	O STD _____
O Artificial Joints or Implants	O Fever Blisters	O Pneumocystis	O Yellow Jaundice
O Artificial Heart Valves	O Frequent Headaches	O Psychiatric Problems	O Bleeding/Clotting Disorder
O Asthma	O Glaucoma (Wide or Narrow)	O Radiation Therapy	O Leukemia
O Blood Transfusion	O HIV Infection/ AIDS	O Rheumatic Fever	O Heart Murmur
O Cancer/Chemotherapy	O Hay Fever	O Seizures	O Heart Disease/Trouble
O Colitis/Stomach Troubles	O Heart Attack/Heart Surgery	O Shingles	O Organ Transplant
O Congenital Heart Defect	O Hemophilia	O Sickle Cell Anemia	O Respiratory Disease
O Cosmetic Surgery	O Hepatitis Type: _____	Other: _____	_____

Authorizations and Release:

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for service. I agree to be financially responsible for payments for all services rendered at each appointment on my behalf to my dependents. In the event that my payment is not received within 90 days of its due date. I agree to pay all costs of collection including attorney fees, collection fees, and contingent fees to collection agencies of not less than 35%, such contingency fee to be added and collected by the collection agency immediately upon your default and our referral of your account to said collection agency.

X_____ _____

Patient signature and/or financially responsible party (parent or guardian if a minor) Date