D. Bradley Dean, D.D.S, M.S.

Reconstructive Periodontal & Implant Microsurgery

Periodontal Plastic Surgery, Pre-Prosthodontic Surgery, Dental Implants, Conscious Sedation

PATIENT DEMOGRAPHIC INFORMATION

Mr. Mrs. Miss Ms. Dr.____

Last First Middle Initial

I wish to be called at: home work other_____________ Name of Spouse/Partner________________________

Address ____Apt. No. ____________

City, State, Zip ____

Home Phone (____)_______________Work Phone (___)___________________________Ext.#____________

Birthdate ___________________________________ Social Security # _________-_________-____________

Referred by ___________________________________Your General Dentist _____________________________

(If Different from Referral)

DENTAL INSURANCE INFORMATION

Primary Insurance	**Secondary Insurance**
Name of insured___________________________	Name of Insured________________________
Relationship to Patient_______________________	Relationship of Patient___________________
Insured's Birthdate _________________________	Insured's Birthdate ______________________
Soc. Sec. # ___________-_______-___________	Soc. Sec. #__________-________-_________
Employer________________________________	Employer _____________________________
Insurance Co. ____________________________	Insurance Co. __________________________
Group # ________________________________	Group # _______________________________
Group Name ______________________________	Group Name ___________________________

___I am not covered by any Dental Insurance at this time

I hereby authorize D. Bradley Dean,DDS,MS, or his staff to release any and all medical and dental information pertinent to my treatment to the above named insurance carrier(s) for the purposes of pre-authorization of treatment plan and fees, claims processing, utilization review or financial audit. In addition, I hereby authorize insurance payment directly to D. Bradley Dean.DDS,MS of the medical and dental benefits otherwise payable to me, for the services rendered to me by either doctors or their staff. I have been informed that this office will report my diagnosis, treatment and fees to my carrier(s) in accord with standards conforming to the current procedures established by the American Academy of Periodontology, and that it is the sole

power and responsibility of my carrier(s) to determine the actual dollar amounts of benefits for all services rendered. I understand that I am ultimately responsible for the total costs of my treatment provided by D. Bradley Dean,DDS,MS.

Cancellation Policy: There will be a substantial charge if a surgical treatment appointment is canceled with less than 3 working days notice. All other appointments require 1 full working days notice for any change. Please remember this time is reserved exclusively for you. Your courtesy in doing this may allow someone else to be seen in a timelier manner.

Payment: There is a 5% discount for full payment by cash or check at the time services are rendered for major services. Payment by credit card receives a 2% discount under the same conditions. We request that all balances be paid in full within 90 days of treatment, unless specific financial arrangements are made before treatment.

I acknowledge that I have read and understand the above statements and policies, and that this authorization remains valid and effective from the date of signing until revoked in writing.

____ ______________________________

Signature of Patient or Patient's Legal Guardian Date of Signature

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Health Questionnaire

Physician: ____ Your HMO I.D. #: __________________________

Address: ____ City: _____________________ Phone: __________________________

Your Age: ______ Height: ______ Weight: ______ Mo/Year of your last medical examination: ______

How would you describe your present health (circle one): excellent good fair poor don't know

Has there been any change in your general health in the past year? (Check for Yes, No, or ?)

Y N ?

☐ ☐ ☐ Have you had a serious illness, operation or hospitalization during the past five years?

If yes, please describe:

☐ ☐ ☐ Are you taking or have you recently taken any of the following:

Prescribed medications:

Over the counter, natural or herbal preparations:

☐ ☐ ☐ Have you ever taken Pondimin (fendluramine) , Phen-Fen (Phentermine) or Redux (dexphenfluramine) for weight reduction?

☐ ☐ ☐ Has your M.D. told you to take antibiotics prior to having any type of dental procedure?

☐ ☐ ☐ Are you allergic to any medications or drugs, latex, iodine?

☐ ☐ ☐ Have you ever had adverse reaction to any drugs, anesthetics, sedatives, narcotics, aspirin, ibuprofen (motrin)?

☐ ☐ ☐ Have you ever had excessive bleeding that required special treatment?

☐ ☐ ☐ Have you been diagnosed as having any Immunodeficiency, ARC or AIDS?

☐ ☐ ☐ Is there a history of diabetes in your family?

☐ ☐ ☐ Are you required, due to health, to restrict your work or activity in any way?

☐ ☐ ☐ Are you on a speical or restricted diet of any kind?

☐ ☐ Do you use any kind of tobacco? If so how much: per day, week, month

☐ ☐ Do you use any kind of alcohol? If so how much: per day, week, month

❑ ❑ ❑ Do you have any history of substance abuse or do you currently use recreational drugs?

For women, check all that are appropriate: ❑ I am pregnant ❑ I am nursing ❑ I am taking birth control pills

Check all of the following that you may have had in the past or that currently apply to you:

❑chest pain upon exertion	❑hepatitis or jaundice	❑history of cancer	❑stroke
❑shortness of breath	❑received bloodtransfusion		❑headaches
❑high blood pressure	❑impaired liver function	❑asthma	❑migraines
❑low blood pressure	❑kidney disease	❑bronchitis	❑epilepsy
❑heart valve prosthesis	❑impaired kidney function	❑emphysema	❑seizures
❑mitral valve prolapse	❑esophygeal reflux	❑sinus troubles	❑mental health problems
❑congenital heart lesion	❑hiatal hernia	❑persistent cough	
❑rheumatic fever	❑g.i. ulcers	❑tuberculosis	❑glaucoma
❑heart murmur	❑anorexia or bulemia		❑wear contact lenses
❑damaged heart value	❑eating disorder	❑joint replacement surgery	❑severely impaired vision
❑heart arrthymiia	❑diabetes	❑arthritis	
❑tachycardia		❑connective tissue disorder	❑recurrent infections
❑heart surgery	❑radiation therapy		❑chronic fatigue
❑cardiac pacemaker	❑chemotherapy	❑neurological disorders	❑recent weight loss

Do you have any disease, problem or condition not listed above? Please explain:

Signature of patient or legal guardian Date: Reviewed by

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Dental Questionnaire

Your Dentist's Name: ____ For how long: __________

How frequently have you had your teeth cleaned during the past 5 years:

☐less than once a year ☐once a year ☐twice a year ☐three times a year ☐four times a year

Mo/Year of your last dental exam: ______________ Mo/Year of your last dental x-rays: ______________

Are you presently satisfied with the condition of your mouth and teeth:

☐very satisfied ☐satisfied ☐it's o.k. ☐somewhat dissatisfied ☐very dissatisfied

Y N (check Yes or No for the following questions:)

☐ ☐ Do you presently have any pain, discomfort or impaired function related to your mouth?

If yes, please describe?

☐ ☐ Are you currently aware of any infection in your mouth?

If yes, please describe:

☐ ☐ Are you currently taking any antibioitics for infection? If so, what:

☐ ☐ Do your gums ever bleed? If so, when:

☐ ☐ Do you have a problem with bad breath or have any friends or family made you aware of this?

☐ ☐ Are you interested in replacing lost teeth?

☐ ☐ Do you ever have aches or pains in your jaw joints, ears, face, neck or head?

☐ ☐ Are any of your teeth tender when you chew hard foods?

☐ ☐ Are any of your teeth more sensitive to: cold, hot, sweets, certain foods or drinks?

☐ ☐ Are any particular teeth very sensitive or painful? when?

☐ ☐ Are you concerned about gum recession around any of your teeth?

☐ ☐ Are you concerned about the appearance of your teeth or mouth?

☐ ☐ Have you ever had Orthodontic treatment? ☐with braces ☐with removable appliances

When did you go through Orthodontic care?

☐ ☐ Have you ever received Periodontal treatment? ☐scaling/root planing ☐gum surgery

When did you go through Periodontal care?

Check any of the following that describe you or makes dental treatment easier for you:

☐ I tolerate most dental care reasonably well and usually require minimal use of anesthesia

☐ I aprpeciate the use of local anesthetic - it allows me to tolerate most dental care reasonably well

☐ I tolerate shots in my mouth when they are given well

☐ I like the benefits of nitrous oxide (laughing gas)

☐ I prefer to be sedated for any surgical treatment

☐ I prefer to be sedated for any lengthy surgical care

☐ I have a hard time sitting in the dental chair for more than an hour

☐ I have a hard time sitting in the dental chair very long due to a neck, back, spine problem

☐ I have difficulty when tilted back in the dental chair (dizziness, breathing difficulty,

What are your goals or priorities for the health, function and appearance of your teeth & mouth:

(rate each item from 1to 5 with 1 being your lowest priority and 5 your highest - you can use the same number more than once)

be able to chew food and eat what I enjoy

preserve my teeth & avoid dentures

be free of infection

be free of mouth pain & tenderness

avoid removable bridgework

for my mouth to look nice when I smile

make my teeth look good

have a healthy and hassle-free mouth

Signature of patient or legal guardian Date Reviewed by