MK PERIODONTICS AND IMPLANTS
MEDICAL HISTORY AND QUESTIONNAIRE

Patient Registration

Date: ______________________

Patient Name:

Name:________________________________ Birthdate:_________ Social Security Number:_________________

Address:____ City____________________ Zip__________________

Gender:____________________ Marital Status:____

Employer:____ Occupation:___________________________________

Phone Numbers: Home:_____________________ Work:_________________________ Cell:_____________________

Email address:_____________________________________ Preferred method of confirmation:________________

Spouse/Partner ______________________ Birthdate___________ Social Security #______________________

Employer:____ Occupation:__________________________________

Work Phone:______________________ Cell Phone: ____________________ Email:_____________________________

If patient is a minor, please complete the following:

Name of person responsible for this account:____________________________

Relationship to Patient: ____

Address ____ City_________________________________ Zip___________

Birthdate:__________ Social Security #___________________________ Home Phone: _______________________

Employer_________________________ Occupation________________ Work Phone _________________________

General Information:

Patient's General Dentist :_____________________________________

Patients Orthodontist:____ Phone________________________

Other people involved in Care:____

Patients Physician:____ Phone:________________________

Emergency Contact:____________________________________ Phone: ________________________

Insurance Information:

Primary Dental Coverage:

Insurance Company: _________________________

Claims Address:_____________________________

Policy Holder:________________________

Birthdate:_____________ ID#_________________

Employer______________ Group#______________

Secondary Dental Coverage:

Insurance Company: ___________________________

Claims Address:_________________________________

Policy Holder: __________________________________

Birthdate:_____________ ID#_____________________

Employer________________ Group#______________

Primary Medical Coverage

Insurance Company: _________________________

Claims Address:_____________________________

Policy Holder:_______________________________

Birthdate:_____________

Employer_______________________________

Group #_________________________________

ID#___________________________________

DENTAL HISTORY AND QUESTIONNAIRE

What is your estimation of your dental health? □ Excellent □Good □Fair □Poor

Is your mouth comfortable now? □Yes □No

If no, please describe the discomfort or problem:

____

____

____

Do you have any active dental disease in your mouth that you are aware of?
□Yes □No

How long have you been with your present general dentist? _________________________

How much dentistry has been performed on your mouth this year? ___________________

Do any members of your family presently have or have they had in the past: (please list relationship to you)
□Dentures____
□Periodontal disease____

Are you satisfied with the appearance of your teeth? □Yes □No

What would the loss of your natural teeth mean to you?

____

____

What are your goals and expectations of periodontal therapy?

____

____

Have you ever had any serious trouble associated with a previous dental experience? Please specify:

____

____

Please list any other comments regarding your teeth, mouth, or dental history:____

____

____

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Patient Name: ______________________________ Date: ________________________

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

Please type YES

I. Skin
Itching ________________________
Rash ________________________
Ulcers ________________________
Pigmentations____________________
Lack or loss of body hair______________

II. Extremities
Varicose veins___________________
Swollen, painful joints_______________
Muscle weakness, pain______________
Bone deformity, fracture_____________
Osteoporosis/Osteopenia (circle one)

Joint Replacements_________________
Prosthetic joints__________________
Type:____________________

Premed required/type:______________

III. Eyes
Blurring vision____________________
Double vision____________________
Drooping of eyelid_________________
Glaucoma_______________________

IV. Ear, Nose, Throat
Dry Mouth______________________
Earache_________________________
Frequent nosebleeds________________
Sinusitis_________________________
Frequent sore throat_______________
Hoarseness_______________________

V. Respiratory
Sleep Apnea____________________
Do you use a CPAP machine?________
COPD__________________________
Cough, blood in sputum_____________
Emphysema, bronchitis______________
Wheezing, asthma_________________
Tuberculosis ______________________

VI. Cardiac
Shortness of breath________________
Pain, pressure in chest______________
Swelling of ankles_________________
Arrhythmia______________________
High/low blood pressure_____________
Cholesterol_____________________
Rheumatic or scarlet fever___________
Heart Murmur, attack______________
Prosthetic valves/pacemakers________

VII.Gastointestinal
Difficulty swallowing_____________________
Abdominal pain, ulcers___________________
Hepatitis, jaundice______________________
Liver disease___________________________
GERD_______________________________

VIII. Genitourinary
Difficulty, pain on urination_______________
Blood in urine_________________________
Excessive urination______________________
Kidney infections_______________________
Sexually transmitted diseases_____________

IX. Endocrine
Thyroid Trouble__________________________
Weight change_________________________
Diabetes/Type___________________________
Result/Date most recent HbA1c:____________
Excessive thirst__________________________

X. Hematopoietic
Easy bruising, excessive bleeding____________
Persistent lymphadenopathy_______________
G6PD deficiency_________________________
Anemia_______________________________
HIV infection, AIDS_______________________
Leukemia, **problems with immune system**________
Spleen problems__________________________

XI. Neurologic
History of Head or Facial Trauma___________
History of Stroke or TIA___________________
Frequent headaches______________________
Dizziness, fainting_________________________
Epilepsy_______________________________
Neuritis, neuralgia_______________________
Tingling/Burning, numbness_______________
Paralysis_______________________________

XII. Psychiatric
Nervousness____________________________
Irritability______________________________
Depression, Anxiety_____________________
Nervous breakdown______________________

XIII. Growth or Tumor
Radiotherapy/chemotherapy________________

MK PERIODONTICS AND IMPLANTS
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Yes/No

Do you smoke tobacco and/or consume other recreational drugs?
Do you use smokeless tobacco?
History of alcohol or drug abuse?

Do you take or have you taken any of these medications?

__ Etidronate (Didronel)
__ Tiludronate(Skelid0
__ Neridronate
__ Alendronate (Fosamax)
__ Ibandronate (Bondronat/Boniva)
__ Risendronate (Actonel)
__ Clodronate(Bonefos, Loron)
__ Pamidronate (Aredia)
__ Olpadronate
__ Zolendronate (Zometa)

List all medications/supplements you take and for what:

____
____
____
____
____

List all medication that cause **allergic reactions and symptoms:**________________________
____

Are you an organ donor/recipient? **Yes/No**_________

Other disease not listed?____

____

FOR WOMEN: **Yes/No**

Pregnant/Due Date:___________________________ Nursing:

Contraceptives/other hormones:____________________ **Yes/No**

Have you noted a change in your menstrual pattern?

Menopausal/premenopausal?

FOR MEN: **Yes/No**

Do you have a history of prostate cancer/prostate enlargement?

Do you take medications for erectile dysfunction?

I certify that any and all questions I had about the inquiries above have been answered to my satisfaction. I was asked all of the questions on this form and I have answered these questions truthfully and completely. I will not hold my dentist, or any other member his/her staff, responsible for any errors or omissions that I may have made.

_______________ ____
Date **Signature of Patient**

_______________ ____
Date **Signature of guardian(where applicable)**

MK PERIODONTICS AND IMPLANTS

FINANCIAL RESPONSIBILITY

Many patients have a commonly held misconception that medical and dental benefit policies that their employers, or they have purchased individually, will pay for all of their treatment. THAT IS INCORRECT AND UNTRUE.

As a patient in our office, you will receive treatment that is specific to the problems that are noted during your examination. Your doctor will carefully review his/her findings with you and explain to you the treatment options (if any) that are available to you. In return, your financial responsibility for the treatment that you agree to will be to the doctors' office. We will be glad to assist you in obtaining reimbursement for part of these benefits from your medical and/or dental insurance.

Often insurance companies, upon the patients' request, will send benefit reimbursement directly to the doctors' office. Please understand that your benefits contract will always have an allowable benefit payment for each procedure performed and that all allowable benefit is determined by the limitations of the contract that your employer or you have personally purchased from the insurer and does not always equal the doctor's submitted fee. Your insurance plan will pay only a percentage of the allowable benefit your employer or you have bought as part of your plan with a co-payment portion then being assigned to you. You are responsible to your doctor for payment of your yearly deductible, if not already satisfied, the patient co-payment portion, and any remaining portion of your doctor's bill that is not covered by your insurance plan.

We will be happy to discuss with you financial arrangements for the payment of your bill, whether or not you have medical/dental insurance available to you. Please understand that third party payment is NOT a guarantee of benefits payment, even though you may feel that you have the coverage under your insurance policy(ies). Financial responsibility for all services received at this office is yours alone. We will gladly work with you to arrange payment for services provided, and these arrangements will be set up on an individual needs basis.

Thank you for your confidence in our office and our doctors. We look forward to providing you with exceptional care and courteous service.

Sincerely,
MK Periodontics & Implants

I HAVE READ THE ABOVE FINANCIAL RESPONSIBILITY STATEMENT AND UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO MK PERIODONTICS & IMPLANTS, DRS. KARBAKHSCH AND KATAFUCHI, FOR ALL CARE AND SERVICES PROVIDED TO ME.

Patient Name___________________________ Date________________________

Signature_______________________________ Date________________________

MK PERIODONTICS AND IMPLANTS

I authorize the release of my dental records from MK Periodontics and Implants, Drs Karbakhsch and Katafuchi, to individuals involved in my dental care. I further authorize the release of records from any individuals to Drs. Karbakhsch, Katafuchi, and/or associates.

I authorize release of medical information to insurance companies needed for the processing of your claims.

I authorize insurance payments to be made directly to MK Periodontics and Implants, Drs. Karbakhsch and Katafuchi. I understand that I am responsible **for any unpaid balance.**

I authorize photos, slides, filming, x-rays or any other viewing of my care and treatment during or after its completion to be used for the advancement of dentistry. My identity will not be revealed to the general public.

I am aware that should I not provide three business days' notice to change an appointment, I may be charged a fee. ($200 per hour for a surgical appointment and $50 per hour for a cleaning appointment)

I am aware of and have received notice of the Health Insurance Portability and Accountability Act (HIPPA)

NOTICE OF PRIVACY PRACTICES-ACKNOWLEDGMENT

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your records or get more information about it by contacting us.
By signing below I acknowledge receipt of the Notice of Privacy Practices.

AUTHORIZATION FOR APPOINTMENT CONFIRMATION

As a courtesy to our patients, we often will give a variety of appointment reminders. Some of these reminders may generally include, but are not limited to, appointment post cards sent through the mail, messages left with roommate/family members, and voicemail messages. Usually within these reminders a certain amount of specific and detailed information, consisting of the patient's appointment time and date, or need for an appointment may be included.

By my signature below, I authorize the office of MK Periodontics and Implants, Drs Karbakhsch and Katafuchi and their staff to confirm my appointment and remind me of the need for an appointment in the above mentioned ways, for the duration of my treatment with their office.

Patient's Signature____ Date___________

Parent or Guardian (if Patient is a Minor) ______________________________ Date___________

This form will be retained in your dental record.