Creating Healthy Smiles
Dr. Fred Alger
PERIODONTICS & DENTAL IMPLANTS
Practice Limited to Periodontics and Dental Implants

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Patient Account Information

Patient's Full Name _____ Nickname _____

Address _____ City _____ Zip _____

Home Phone (_____) _____ Cell Phone (_____) _____ Work Phone (_____) _____

Email Address _____ SS# _____ Date of Birth _____Age_____

Marital Status_____ If Married, Spouse's Name_____

If a Minor, Name of Parents/Guardians_____ SS#_____

Pharmacy_____ Pharmacy Address_____ Pharmacy Number (_____) _____

Physician's Name_____ Physician's Number (_____) _____

Physician's Address_____ City_____ Zip_____

In case of Emergency, Contact (Other than Spouse) _____ Phone (_____) _____

Dentist's Name _____ Who Referred You to Dr. Alger? _____

Insurance

Primary *Dental* Insurance Co. _____ Phone (_____) _____

Dental Insurance Address_____ City _____ Zip _____

Group (Employer) Name_____ Group # _____ Subscriber ID#_____

Name of Insured Subscriber (Who's name is insurance under?) _____

Relationship of Insured to Patient_____ Insured's Birth Date_____ S.S.#_____

Secondary *Dental* Insurance Co._____ Phone (_____) _____

Dental Insurance Address_____ City _____ Zip _____

Group (Employer) Name_____ Group # _____ Subscriber ID#_____

Name of Insured Subscriber (Who's name is insurance under?) _____

Relationship of Insured to Patient_____ Insured's Birth Date_____ S.S.#_____

I understand and agree that I am financially responsible for payment of all charges incurred, which are not paid by insurance benefits. I understand that charges due by the patient not paid within 30 days of billing may be subject to late payment fees unless financial arrangements are approved in advance. I understand that there will be a return check fee of $45.00. We reserve the right to charge for appointments cancelled or broken without 48 hours advance notice.

Signature_____ Date _____

Medical/Dental History

1. Please list any prescription or non-prescription medications that you are taking, and the reason why.

Medication	**Reason**

2. Do you have, or have you ever had any of the following conditions? (Check all that apply)

☐Abnormal or Prolonged Bleeding	☐Difficulty Breathing	☐Pacemaker
☐Alcohol or Drug Dependence	☐Epilepsy, Seizures	☐Pain Patch (Fentanyl)
☐Allergies	☐Fainting Spells	☐Psychiatric Treatment
☐Alzheimer's Disease, Dementia	☐Fever Blisters, Cold Sores	☐Radiation Therapy
☐Angina Pectoris	☐Frequent Headaches	☐Recurrent Pain in Face
☐Arthritis	☐Glaucoma	☐Shingles
☐Artificial Heart Valve, Valve Replacement	☐HIV	☐Sinus Problems
☐Artificial Joints, Joint Replacement	☐Currently Pregnant or Nursing	☐Sleep Apnea
☐Asthma	☐Heart Attack, Heart Disease	☐Stomach Problems
☐Atrial Fibrillation (AFIB)	☐Heart Surgery, Heart Stent	☐Stroke, Aneurysm
☐Blood Clots Requiring Treatment	☐Heart Valve Trouble	☐TMJ Pain or Disorders
☐Blood Disorder, Anemia	☐Hepatitis	☐Thyroid Problems
☐Cancer	☐High Blood Pressure	☐Tuberculosis
☐Chest Pain	☐Kidney or Bladder Problems	☐Tumor or Growth
☐Clicking or Popping of Jaws	☐Liver Disease	☐Ulcers
☐Colitis, Colon Disease	☐Lung Disease	☐Venereal Disease, STD's
☐Diabetes	☐Osteoporosis, Osteopenia (If yes, please list all medications above)	

☐Other: _____

Are you allergic to, or had an adverse reaction to any of the following medications? Check all that apply.

☐Acetaminophen (Tylenol)	☐Clindamycin, Doxycycline, Tetracycline	☐Local Anesthetics (Numbing Agents)
☐Amoxicillin/Penicillin	☐Codeine, Hydrocodone (Vicodin)	☐Narcotics (Demerol, Nubain)
☐Aspirin, Advil (Ibuprofen)	☐Latex	☐Versed (Midazolam)/Valium (Diazepam)

☐Other:_____

Medical/Dental Questionnaire

Name_____ Date_____

1. Have you ever had a serious accident or been hospitalized? If yes, please explain._____

_____

2. Are you currently under the care of a physician? If so, for what condition? _____

_____

3. Do you take aspirin daily? _____

4. Do you have dental pain or any other dental condition that you believe requires immediate attention today? If so, please explain. _____

_____

5. Do your gums bleed? If yes, when? _____

6. Did either of your parents lose most or all their teeth? If so, please explain. _____

_____

7. Have you ever been treated for gum disease? (i.e. deep scaling, root planing, gum surgery) If yes, please explain. _____

_____

8. Have you had any serious trouble with previous dental treatment? If yes, please explain. _____

_____

9. Do you use dental floss or a waterpik? If so, how often? _____

10. How often do you brush your teeth? _____

11. What type of toothbrush do you use? ☐Soft Bristle ☐Medium Bristle ☐Hard Bristle ☐Electric

12. What is your primary reason for coming to the periodontist? _____

_____

13. How upset would you be if you lost your teeth and had to wear dentures? Check below.

☐Very Upset ☐Somewhat Upset ☐Not Very Upset

14. What is the most important thing that you want Dr. Alger to know about you or the health of your mouth? _____

15. Is there any other medical or dental condition or problem that you think this office should know that was not covered above? If yes, please describe. _____

_____

To the best of my knowledge, the above answers are true and correct. If I ever have a change in my health or medications, I will inform Dr. Alger at the next appointment.

Signature_____ Date_____