MK PERIODONTICS AND IMPLANTS
MEDICAL HISTORY AND QUESTIONNAIRE

Patient Registration

Date: _____

Patient Name:

Name:_____ Birthdate:_____ Social Security Number:_____

Address:_____ City_____ Zip_____
Gender: Male/Female Marital Status: Single/Sig Other/ Married/ Divorced/ Widowed
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 circle all that apply

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
MEDICAL HISTORY AND QUESTIONNAIRE

Do you smoke tobacco and/or consume other recreational drugs? **Yes/No**
Do you use smokeless tobacco? **Yes/No**
History of alcohol or drug abuse? **Yes/No**

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:

Pregnant/Due Date:_____ Nursing: **Yes/No**
Contraceptives/other hormones (circle one) **Yes/No**
Have you noted a change in your menstrual pattern? **Yes/No**
Menopausal/premenopausal? **Yes/No**

FOR MEN:

Do you have a history of prostate cancer/prostate enlargement? **Yes/No**
Do you take medications for erectile dysfunction? **Yes/No**

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, KATAFUCHI, AND/OR SU 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, Katafuchi and/or Su to individuals involved in my dental care. I further authorize the release of records from any individuals to Drs. Karbakhsch, Katafuchi, Su 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, Katafuchi and/or Su. 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, Katafuchi and/or Su 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.