Nicholas Caplanis D.M.D., M.S.
Periodontics and Implant Surgery

We realize that it is a contradiction to politely say "Welcome" and to immediately request that you complete these forms in the same sentence. However, it is vital that we obtain accurate, pertinent information in order to render the best possible treatment. Therefore, we must ask for your indulgence and request the inevitable. Please complete the following 4 forms. All information will be kept completely confidential. By the way, this is not an examination and no grade will be given, so if you have any questions or would like assistance, please ask. Thank-you and welcome to our office!

I. Personal Information

Please Print
Who may we thank for this referral?_____

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.
PATIENT NAME _____ (First) _____ (Last) _____ (Middle) Date _____
Date of Birth _____ / _____ / _____ Age _____ Sex: M F

Marital Status ____ Single ____ Married ____ Widowed ____ Separated ____ Divorced
Home Address _____ City_____State _____ Zip_____
Home Phone _____ Home Fax _____E-mail _____

Person Responsible For This Account (If patient is a minor or adult dependent)
Responsible Party _____Relationship _____
Address _____ City_____State _____ Zip_____
Phone _____ Fax _____ E-mail _____

YOUR EMPLOYER _____
Employer Address _____ City_____State _____ Zip_____
Employer Phone _____ Employer Fax _____E-mail _____

SPOUSE NAME _____ (First) _____ (Last) _____ (Middle) Date of Birth ___/___/___
Spouse Employer _____
Employer Address _____ City_____State _____ Zip_____
Employer Phone _____ Employer Fax _____E-mail _____

In the event of an Emergency, who should we contact?

Emergency Name _____Relationship _____
Home Phone _____Work Phone _____

Dental Insurance Information Do You Have Dental Insurance Coverage? ☐ YES ☐ NO

Primary Insurance _____Group # / Cert. # _____
Name of Policy Holder_____Birthdate ____/____/____SS#: _____- _____- _____
Necessary for claim submission
Secondary Insurance_____ Group # / Cert. # _____
Name of Policy Holder_____Birthdate ____/____/____SS#: _____- _____- _____
Necessary for claim submission

I Certify that the above given information is true and accurate to the best of my knowledge.

X_____ _____

Signature of Patient, Parent, or Guardian Date

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Periodontics and Implant Surgery

IV. Office Policies

FINANCIAL POLICY
WE ACCEPT CHECKS, VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS, PULSECARD, AND ATM

INSURED PATIENTS

PAYMENT IN FULL is required the day services are rendered for all diagnostic services such as examinations, radiographs (x-rays), and evaluations.

50% PAYMENT is required the day services are rendered for all therapeutic, periodontal, and surgical treatments regardless of insurance benefits available.

PAYMENT IN FULL is required the day services are rendered for all dental implant surgical procedures unless prior financial arrangements are made with the office manager.

NON-INSURED PATIENTS

PAYMENT IN FULL is required on the day services are rendered for all procedures unless prior arrangements are made with the office manager.

LATE CHARGES
A late charge of 1.5% on any unpaid and owed balance past 90 days will be assessed to your account unless prior financial arrangements are made with the office manager. Failure to keep your account current may prevent delivery of additional dental services, except for dental emergencies or where there is prepayment for additional services.

INSURANCE POLICY
As a courtesy to our patients, our Insurance Coordinator will assist you in obtaining benefits for all services delivered. A formal request to our Insurance Coordinator is required if you desire a PRE-AUTHORIZATION of your insurance benefits. Your dental insurance carrier may pay less than the actual fee for services. Therefore, all fees incurred are ultimately your responsibility regardless of insurance benefits.

BROKEN/MISSED APPOINTMENTS

Treatment time is specifically reserved for each individual patient. In consideration for all our patients with serious needs for appointments, we request AT LEAST 24 HOURS NOTICE if you are unable to keep your appointment. A $50.00 missed appointment charge will be assessed to your account after the second missed or broken appointment.

1. **I understand the office policy regarding financial arrangements, that payment is required at the time of service, that this policy applies regardless of insurance coverage and that I am ultimately financially responsible for all fees incurred by me or my dependents.**
2. **I understand and agree that if I fail to pay any outstanding balance within ninety (90) days, that my account may, without further notification, be referred for collection; I further agree to pay all reasonable costs incurred for this collection including interest, collection agency costs and/or attorney fees.**
3. **I authorize the release of all medical/dental records regarding all treatments and charges rendered to me or my dependents, to any third party payers or other medical/dental professionals.**
4. **I certify that I have supplied truthful and accurate information to the best of my knowledge.**

X_____ _____

Signature of Patient, Parent, or Guardian Date

South County Periodontics and Implant Dentistry

Nicholas Caplanis D.M.D., M.S., Inc.

II. Medical / Dental History

Name_____ Age_____ Height ____' ____" Weight _____lbs. Date_____
Last First Middle

1. Are you in good health? ..... Yes No
2. Any changes In your general health within the past year?..... Yes No
3. My last physical examination was on _____
4. Are you now under the care of a physician?..... Yes No
   If yes, for what? _____
5. The name and address of my physician(s) is_____
   _____
   Office Address Telephone
6. Have you ever been hospitalized in the past 5 years? ..... Yes No
   If yes, please explain _____
7. Are you ALLERGIC or have you ever experienced a reaction to any of the following?
   - Local Anesthesic..... Yes No
   - Penicillin or Other Antibiotics..... Yes No
   - Sulfa Drugs..... Yes No
   - Barbiturates, Sedatives, Narcotics..... Yes No
   - Aspirin..... Yes No
   - Iodine..... Yes No
   - Codeine..... Yes No
   - Other..... Yes No

8. Have YOU EVER or are you CURRENTLY taking any of the following?
   - Blood Thinners , Aspirin, Coumadin. ..... Yes No
   - Blood Pressure Medications ..... Yes No
   - Insulin / Diabetes Medications..... Yes No
   - Steroids/Cortisone..... Yes No
   - Thyroid Medication ..... Yes No
   - Heart Medications..... Yes No
   - Nitroglycerin ..... Yes No
   - Fosemax ..... Yes No
   - Boniva/Actonel..... Yes No
   - Phentermine ..... Yes No
   - Fen / Phen ..... Yes No
9. Please list ALL medications you are CURRENTLY taking
   _____
   _____
   _____
10. Do you smoke? If yes how much? ..... Yes No
11. Do you drink alcohol? If yes how much?..... Yes No
12. Do you use any illicit drugs or medications?.... Yes No

13. Do you HAVE or have you EVER had any of the following?

GENERAL	YES	NO	CARDIOVASCULAR	YES	NO	RESPIRATORY	YES	NO
Tire Easily, Weakness	☐	☐	Rheumatic Fever	☐	☐	Tuberculosis	☐	☐
Marked Weight Change	☐	☐	Heart Murmur / Heart Defects	☐	☐	Emphysema	☐	☐
Night Sweats	☐	☐	Chest Pain/Discomfort	☐	☐	Asthma/Hay Fever	☐	☐
Persistent Fever	☐	☐	Heart Attack/Heart Trouble	☐	☐	Persistent Cough	☐	☐
Eruptions/Rash/Hives	☐	☐	Shortness Of Breath	☐	☐	Sputum Production/Phlegm	☐	☐
Change In Skin Color	☐	☐	Swelling Of Ankles	☐	☐	Cough Up Bloody Sputum	☐	☐
Visual Change	☐	☐	High Blood Pressure	☐	☐	Difficulty Breathing	☐	☐
Glaucoma	☐	☐	Low Blood Pressure	☐	☐			
Loss Of Hearing	☐	☐	Heart Defects	☐	☐	**BLOOD**		
Ringing In Ears	☐	☐	Mitral Valve Prolapse	☐	☐	Abnormal Bleeding	☐	☐
Frequent Nosebleeds	☐	☐	Artificial Heart Valve	☐	☐	Bruise Easily	☐	☐
Sinus Problems	☐	☐	Pacemaker	☐	☐	Anemia	☐	☐
						Blood Transfusions	☐	☐
NERVOUS SYSTEM			**DIGESTIVE SYSTEM**			Aids/Arc/Hiv	☐	☐
Stroke	☐	☐	Hepatitis	☐	☐			
Convulsions/Epilepsy/Seizures	☐	☐	Jaundice	☐	☐	**NEOPLASMS**		
Headaches	☐	☐	Ulcers	☐	☐	Cancer	☐	☐
Numbness/Tingling	☐	☐	Change In Appetite	☐	☐	Tumors Or Growths	☐	☐
Dizziness	☐	☐	Bloody/Coffee Ground Vomitus	☐	☐	Chemotherapy/Radiation Therapy	☐	☐
Fainting	☐	☐	Black, Bloody Or Pale Stools	☐	☐			
Psychiatric Treatment	☐	☐	Liver Disease / Cirrhosis	☐	☐	**BONE/MUSCLES**		
						Arthritis/Rheumatism	☐	☐
ENDOCRINE			**GENITO / URINARY**			Artificial Joints	☐	☐
Diabetes	☐	☐	Kidney Disease	☐	☐			
Family History Of Diabetes	☐	☐	Frequent Urination	☐	☐	**WOMEN**		
Thyroid Condition/Goiter	☐	☐	Burning On Urination	☐	☐	Are you Pregnant?	☐	☐
			Urethral Discharge	☐	☐	Are you Nursing?	☐	☐
			Bloody Urine	☐	☐	Are You Taking Birth Control Pills?	☐	☐
			Sexually Transmitted Disease	☐	☐			

South County Periodontics and Implant Dentistry

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III. Medical / Dental History

14. Why are you now seeking Dental Treatment? Explain_____

15. Did your Dentist ask you to see me? ..... Yes No
16. Has any Dentist ever suggested that you see a Periodontist? ..... Yes No
17. Do you feel you know and understand what causes Periodontal Disease ..... Yes No
18. Has a dentist ever told you that you will lose all your teeth some day ..... Yes No
19. Do you believe you will lose all or most of your teeth some day? ..... Yes No
20. Do you believe that tooth loss is preventable or treatable? ..... Yes No
21. Are you greatly concerned about losing your teeth and/or facial bone structure? ..... Yes No
22. Do you visit your dentist regularly? ..... Yes No
23. Do your gums bleed or feel sore? ..... Yes No
24. Do you feel you have constant bad breath ..... Yes No
25. Do any of your teeth feel loose? ..... Yes No
26. Are any of your teeth sensitive to hot, cold, sweets or biting? ..... Yes No
27. Have you noticed a change in your bite or shifting of teeth recently? ..... Yes No
28. Do you feel that dentures are an adequate replacement for natural teeth? ..... Yes No
29. When was the last time your teeth were cleaned or scaled? _____
30. Do your jaws pop or click or do you have difficulty opening or closing your jaw? ..... Yes No
31. Have you ever had braces or orthodontic treatment? ..... Yes No
32. Do you have a tremendous fear or become overly anxious when seeing a dentist ..... Yes No
33. Have you ever had a bad or traumatic experience in a dental office? ..... Yes No

If So Explain _____

I certify that I have read and understand the two page Medical / Dental History Forms above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my Doctor, or any other member of his staff, responsible for any errors or omissions that I have made in the completion of these forms.

X_____ _____

Signature of Patient, Parent, or Guardian Date

Medical History Updates:

Date	Please Note Changes in Your Medical History **Since You Last Filled out These Forms**	Patient Signature	Doctor Review

For Completion by the Doctor

Patient management considerations and comments if any:

_____

_____

_____

_____ _____

Doctor Signature Date