WELCOME

ANTHONY R. PECORA, D.D.S., M.S.
PRACTICE LIMITED TO PERIODONTICS AND IMPLANT DENTISTRY
Diplomate of the American Board of Periodontology

1 About You

Today's Date: ______

Name: ______ LAST ______ FIRST ______ MI ______ MR. MRS. MS. DR.

I prefer to be called: ______ ☐ Male ☐ Female

Birthdate: __/__/__ Age: ______ S.S.#: ______

Home address: ______ APT/CONDO#

______ CITY ______ STATE ______ ZIP

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Home #: ______ Pager / Other #: ______

Wk #: ______ Ext. ______

Employer: ______

Employer's address: ______

How long there? ______ Occupation: ______

Where & when are best times to reach you? ______

Whom may we thank for referring you? ______

Other family members seen by us: ______

Present dentist: ______ How long? ______

Last visit date: ______

2 Spouse Information

Name: ______

Employer: ______

Wk #: ______ Ext. ______ S.S. #: ______

Birthdate: ______

Person Responsible for Account: ______
(IF DIFFERENT)

Wk #: ______ Ext. ______ HM#: ______

Billing address: ______ ZIP

Relationship: ______ S.S #: ______

Employer: ______

3 Medical History

How would you describe your health?
☐ Excellent ☐ Good ☐ Fair ☐ Poor

Physician's Name: ______

Are you currently under the care of a physician? ☐ No ☐ Yes

Please explain: ______

Are you taking any prescription/over-counter drugs? ☐ No ☐ Yes

Please list each one: ______

For women: are you taking birth control pills? ☐ No ☐ Yes

Are you pregnant ☐ No ☐ Yes

Have you ever had any of the following diseases or medical problems?

Y N Heart Attack / Stroke	Y N Psychiatric Problems
Y N Cancer / Chemotherapy	Y N Epilepsy/ Seizures/ Fainting Spells
Y N Heart Murmur	Y N Diabetes / Tuberculosis (TB)
Y N Rheumatic Fever	Y N Drug / Alcohol Abuse
Y N HIV+ / AIDS	Y N Venereal Disease
Y N Heart Surgery / Pacemaker	Y N Hemophilia / Abnormal Bleeding
Y N Shingles	Y N Ulcers / Colitis
Y N Mitral Valve Prolapse	Y N Congenital Heart Defect
Y N Kidney Problems	Y N Anemia / Radiation Treatment
Y N Artificial Bones / Joints	Y N Asthma / Arthritis
Y N Artificial Valves	Y N Difficulty Breathing
Y N Sinus Problems / Allergies	Y N Hospitalized for Any Reason
Y N High / Low Blood Pressure	Y N Hepatitis A Infectious / B serum
Y N Fever Blisters	Y N Blood Transfusion
Y N Severe/Frequent Headaches	Y N Emphysema / Glaucoma

Please list any serious medical condition(s) that you have ever had: ______

Has antibiotic premedication been advised before dental visits? Y N

Are you allergic to any of the following drugs?

Y N Penicillin	Y N Tetracycline	Y N Latex
Y N Aspirin	Y N Dental Anesthetics	Y N Barbituates, Sedatives or Sleeping Pills
Y N Erythromycin	Y N Codeine	

Please list any other drugs that you are allergic to: ______

Do you smoke? Y N How Much? ______ Packs per Day

CONTINUED ON BACK

4 DENTAL HISTORY

What is your primary concern about your mouth? ______________________

____

Are you currently in pain? ☐ No ☐ Yes

Have you ever had a serious / difficult problem associated with any previous dental work? ☐ No ☐ Yes

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ)? ☐ No ☐ Yes

Do you like your smile? ☐ No ☐ Yes

Do your gums ever bleed? ☐ No ☐ Yes

How many times a week do you floss? ________

Do you have a water pik? ☐ No ☐ Yes

Have you ever been examined specifically for periodontal disease?

☐ No ☐ Yes When? __________ By whom? ______________

Have you had previous periodontal treatment? ☐ No ☐ Yes

When? __________ By whom? ______________________

What was done? ______________________

Are you very nervous before dental visits? ☐ No ☐ Yes

Do you frequently eat sweets, use mints or gum? ☐ No ☐ Yes

When were your teeth last cleaned? ____________

Are you bothered by persistent bad breath or bad taste in your mouth? ☐ No ☐ Yes

How severe do you consider your gum problem?

☐ Minimal ☐ Generalized moderate ☐ Generalized severe

☐ Localized to 1 or 2 spots

What special concerns or questions do you have about periodontal treatment? ______________________

____

What other information would help us to serve you better?

____

____

5 DENTAL INSURANCE

Primary Dental Insurance

Insurance Co. Name: ______________________

Insurance Co. Address: ______________________

Insurance Co. Phone #: ______________________

Group # (Plan, Local or Policy #): ______________________

Insured's Name: ______________________
Relation:

Insured's Birthday: ______________________

Insured's Employer: ______________________

Secondary Dental Insurance
(IF APPLICABLE)

Insurance Co. Name: ______________________

Insurance Co. Address: ______________________

Insurance Co. Phone #: ______________________

Group # (Plan, Local or Policy #): ______________________

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment. I authorize insurance benefits to be paid directly to the dentist.

____

Signature Date

Thank you for filling out this form completely. It will enable us to help you more effectively. If you have any questions at any time, please ask us. We are happy to help.

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

OFFICE USE ONLY *OFFICE USE ONLY* OFFICE USE ONLY *OFFICE USE ONLY*

I verbally reviewed the medical / dental information above with the patient named herein. Initials ____________ Date ____________

Doctor's Comments: ____

MEDICAL HISTORY UPDATE

1. Date ________ Comments ______________________ Signature ____________
2. Date ________ Comments ______________________ Signature ____________
3. Date ________ Comments ______________________ Signature ____________
4. Date ________ Comments ______________________ Signature ____________
5. Date ________ Comments ______________________ Signature ____________

Office of Dr. Anthony Pecora

CONSENT FOR USE AND DISCLOSURE

OF HEALTH INFORMATION

And

Acknowledgement on Notice of Privacy

Practices

Purpose of Consent: By signing this form, you will consent to disclosure of your health information to carry out of treatment, payment activities, and healthcare operations.

A complete copy of this consent form and our notice of privacy practices are on display in our office for your consideration and you may request a copy. You have a right to revoke this consent at any time. You may refuse to sign this form.

Print Name____ Date______________________

Signature____ Date______________________

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's name____

_____Patient in under the age of 18

_____Individual refused to sign

_____Communication barriers prohibit patient signature

_____An emergency situation prevented obtaining signature