

NORTH HILLS PERIODONTICS, LLC

Charu S. Chandra, D.M.D., M.D.S.

Practice Limited to Periodontics and Implant Dentistry

REGISTRATION AND TREATMENT FORM

Name _____
Last First Middle Initial

Address _____
Street City State Zip Code

Home Phone () _____ Cell Phone () _____

Work Phone () _____ May we call your work number? Y _____ N _____

Email _____ Social Security # _____ - _____ - _____

Date of Birth ____/____/____ Single ____ Married ____ Widowed ____ Separated ____ Divorced ____

Emergency Contact _____ Phone () _____

DENTAL INSURANCE INFORMATION

Insured _____ Relationship to Insured _____

Social Security/ID # _____ Date of Birth ____/____/____

Insurance Company _____ Phone () _____

Group # _____ Employer _____

SECONDARY DENTAL INSURANCE

Insured _____ Relationship to Insured _____

Social Security/ID # _____ Date of Birth ____/____/____

Insurance Company _____ Phone () _____

Group # _____ Employer _____

AUTHORIZATION

I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure payment of benefits.

I understand that I am financially responsible for all charges and my balance regardless of insurance. I understand that I may incur a 12% APR if my balance goes beyond 60 days.

Signature _____ Date _____

DENTAL HISTORY

Referring Doctor _____ Phone () _____

Reason for today's visit _____

Date of last dental visit ____/____/____ Date of last dental x-rays ____/____/____

Check (✓) if you have had problems with any of the following:

- | | | |
|--|--|--|
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Sensitivity to hot |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Loose Teeth | <input type="checkbox"/> Sensitivity to sweets |
| <input type="checkbox"/> Clicking or popping jaw | <input type="checkbox"/> Periodontal treatment | <input type="checkbox"/> Sensitivity when biting |
| <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Sensitivity to cold | <input type="checkbox"/> Sores or growths in mouth |

How often do you brush? _____ How often do you floss? _____

Any other oral hygiene aids? Please list _____

MEDICAL HISTORY

Physician's Name _____ Date of last visit ____/____/____

Have you had any serious illnesses or operations? Yes No

Have you ever had a blood transfusion? Yes No

If yes give approximate date _____

Have you been hospitalized recently? Yes No

If yes describe _____

(Women)

Are you pregnant? Yes No

Nursing? Yes No

Taking birth control pills? Yes No

Check (✓) if you have or have had any of the following:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Aids | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Hepatitis <i>Type</i> _____ | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cough, Persistent | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Cough up Blood | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Swollen Feet/Ankles |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Headaches | <input type="checkbox"/> Nervous Problems | <input type="checkbox"/> Tobacco Habit |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chemotherapy | Describe _____ | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Venereal Disease |

List medications you are currently taking (include vitamins, herbal supplements)

List allergies _____

Signature _____ Date _____