South Jersey Periodontics & Dental Implants, LLC

Daniel Kubikian, DMD

Name: _____

Address (including city, state, zip): _____

Phone: (H) _____ (W)_____ (C)_____ E-Mail: _____

Social Security #: _____ Date of Birth:_____ Preferred Contact Method: _____

Whom may we thank for referring you to our practice? _____

Who is the general dentist? _____

Reason for visit? _____

Have you seen a periodontist before? If so, explain: _____

MEDICAL HISTORY

Patient's Physician: _____ Physician's Phone Number: _____

Are you allergic to: Latex ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Other ☐: _____

Do you require antibiotic pre-medication prior to dental treatment? YES ☐ NO ☐ If yes, please explain: _____

Do you smoke? YES ☐ NO ☐ If yes, how many packs? how often? _____

Do you have Excessive Urination ☐ thirst ☐ hunger ☐ or recent weight changes? _____

Women: Are you taking oral contraceptives or other hormone supplements? YES ☐ NO ☐ If yes, please explain: _____

Have you ever taken bisphosphonates? (Boniva, Actonel, Fosamax, etc.) YES ☐ NO ☐

Other important medical info: _____

Please list medications you are taking: _____

_____

HAVE YOU EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING CONDITIONS?

AIDS:	YES ☐ NO ☐	High Blood Pressure:	YES ☐ NO ☐	Heart Murmur:	YES ☐ NO ☐	Rheumatic Fever:	YES ☐ NO ☐
Anemia:	YES ☐ NO ☐	Low Blood Pressure:	YES ☐ NO ☐	Hepatitis A:	YES ☐ NO ☐	Sinus Trouble:	YES ☐ NO ☐
Arthritis:	YES ☐ NO ☐	Cancer:	YES ☐ NO ☐	Hepatitis B, C:	YES ☐ NO ☐	Stroke:	YES ☐ NO ☐
Artificial Joints:	YES ☐ NO ☐	Diabetes:	YES ☐ NO ☐	Herpes:	YES ☐ NO ☐	Tuberculosis:	YES ☐ NO ☐
Asthma:	YES ☐ NO ☐	Epilepsy:	YES ☐ NO ☐	Cold Sores:	YES ☐ NO ☐	Ulcers:	YES ☐ NO ☐
Hay fever:	YES ☐ NO ☐	Heart Disease:	YES ☐ NO ☐	Hypoglycemia:	YES ☐ NO ☐		

PERIODONTAL HEALTH

Last Dental Visit: _____

How often do you brush your teeth? _____

What texture toothbrush do you use? Soft ☐ Medium ☐ Hard ☐

Do you floss your teeth? YES ☐ NO ☐ How Often? _____

Are your teeth sensitive to cold liquids or foods? YES ☐ NO ☐

Do your gums bleed when brushing/flossing? YES ☐ NO ☐

Do your gums feel swollen or tender? YES ☐ NO ☐

Do you have any problems chewing? YES ☐ NO ☐

Are any teeth loose? YES ☐ NO ☐

Signature of Patient (parent/guardian if under 18): _____

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Responsible Party Information (Skip if self)

Name: _____ Date: _____

Address (including city, state, zip): _____

Social Security #: _____ Date of Birth: _____

Phone: (H) _____ (W) _____ (C) _____ E-Mail: _____

Dental Insurance Information (If applicable)

Primary

Policy Holder Name: _____ Employer Name: _____

Insurance Company Name: _____ Group #: _____ Phone Number: (_____)_____- _____

Social Security #: _____-_____-_____ Member ID #: _____ Birth Date: _____

Relationship to patient: Self ☐ Spouse ☐ Child ☐ Other ☐

Secondary (If applicable)

Policy Holder Name: _____ Employer Name: _____

Insurance Company Name: _____ Group #: _____ Phone Number: (_____)_____- _____

Social Security #: _____-_____-_____ Member ID #: _____ Birth Date: _____

Relationship to patient: Self ☐ Spouse ☐ Child ☐ Other ☐

Financial Consent for Service

***Please read and initial next to each item*

_____ As a condition of your treatment by this office, it is your obligation to inquire about financial arrangements in advance.

_____ All dental services must be paid for at the time the services are performed.

_____ Patients who carry dental insurance "in-network" with our office understand that they are responsible for their portion due (according to their dental plan) at the time of the visit. Furthermore, patients understand that they are responsible for any unpaid balance by their insurance company.

_____ Any unpaid balance exceeding 90 days from the date of service was rendered will be subject to third party collection. I agree to pay all costs associated with the collection of the unpaid balance.

_____ I understand that if an appointment is cancelled less than 48 hours notice there may be a fee equivalent up to 25% of the procedure imposed.

_____ I grant my permission to you or your assignee, to telephone me to discuss matters related to this form.

_____ I consent and authorize South Jersey Periodontics & Dental Implants, LLC and/or Dr. Kubikian to use my radiographs, periodontal charting, impressions and/or clinical photographs for the purpose of communicating with insurance companies, dental providers, or any other lawful purpose. [release and forever discharge any claim, demands or liability on account of such use.]

I have read the above conditions of treatment and payment and agree to their content.

Signature of Patient (parent/guardian if under 18): _____ *Date:* _____

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Written Financial Policy

Thank you for choosing ***South Jersey Periodontics and Dental Implants, LLC***. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of our mission is making the cost of optimal care easy and manageable for our patients by offering several payment options.

Payment Options:

- Cash or Check
- Visa, MasterCard, American Express, or Discover Card
- Convenient Monthly Payment Plans from CareCredit or Chase (Subject to credit approval.)
  - o Allows patients to pay over time
  - o No annual fees or pre-payment penalties

Please note:

South Jersey Periodontics & Dental Implants, LLC requires payment on the date of service.

For patients with dental insurance, we are happy to work with the carrier to maximize benefits and directly bill them for treatment fee reimbursement.

- However, if we do not receive payment from the insurance carrier, patients will be responsible for any remaining balance.

A fee of up to 25% of the procedure fee is charged for patients who miss or cancel without 48-HOUR NOTICE.

South Jersey Periodontics & Dental Implants, LLC charges $30 for returned checks.

If there are any questions, please do not hesitate to ask. We welcome the opportunity to help and provide the care our patients want and need.

Patient, Parent or Guardian Signature: _____ ***Date:*** _____