CAMARILLO PERIODONTICS

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Practice Limited to Periodontics and Dental Implants
The Courtyard • 3801 Las Posas Road, Suite 205, Camarillo, CA 93010
Phone: 805-388-1730 • Fax 805-388-2994

Personal History

Date: ___/___/___

Patient's Name: _____ (_____)
Last First MI Nickname

Home Address: _____ City_____ State ____ Zip _____

Home Phone: (___) _____ Cell Phone: (___) _____ SS#_____

Sex [ ] male [ ] female Age _____ Date of Birth ___/___/___ Marital Status _____

May we contact you on your cell phone to discuss appointments, insurance, financial etc. [ ] Yes [ ] No

Employer's Name and Address _____ E-Mail Address: _____

if student School: _____ Grade ____

Person to contact for emergency _____ Phone # (___) _____

Dentist _____ Physician _____

Who may we thank for referring you _____

Spouse or Responsible Party (if patient is Minor)

Person responsible for account _____ Relationship to Patient _____

Address (if different from above) _____ Home Phone # (___) _____

Name of Employer _____ Work Phone # (___) _____

SS# ____ - ____ - ____ D.L. # _____ State ____ DOB: _____

Primary Dental Insurance

Insurance Company Name & Address _____

Group # _____ Phone # (___) _____ SS# _____ DOB: _____

Insured Name: _____ Relationship to patient _____ Home Phone # (___) _____

Employer's Name: _____ Work Phone # (___) _____

Secondary Dental Insurance

Insurance Company Name & Address _____

Group # _____ Phone # (___) _____ SS# _____ DOB _____

Insured Name: _____ Relationship to patient _____ Home Phone # (___) _____

Employers Name: _____ Work Phone # (___) _____

Your insurance is processed as a courtesy. I understand that I am financially responsible for all services rendered regardless of any benefits my insurance policy (if any) covers. Payment is due at the time services are rendered. Should this account become delinquent and require collection procedures Camarillo Periodontics, will be entitled to any fees and/or costs, which may occur in order to obtain payment in full.

DATE ___/___/___ SIGNATURE _____ Relationship to Patient_____

Medical History

All answers will be held in strict confidentiality.

What is the reason for your visit today:_____

Do you have any medical conditions, If yes, please explain_____

_____

Please list any medicines you are taking: _____

_____

Herbal Supplements/Vitamins: _____

Are you allergic or have adverse reactions to: [ ] Aspirin [ ] Barbiturates [ ] Codeine

[ ] Local Anesthetics [ ] Penicillin [ ] Sulfa [ ] Latex [ ] No known drug allergies

[ ] Other_____

Height: _____ Weight: _____

Do you smoke?_____Packs per day_____Do you drink alcohol?_____Drinks per day _____

Do you use recreational drugs?____ **Women**: Are you pregnant? Yes No # Mo_____ Nursing? Yes No

Birth Control pills? Yes No

Circle **Yes**, if you have ever had any of the following:

High blood pressure	Yes	No	Rheumatic / scarlet fever	Yes	No	Arthritis/rheumatism	Yes	No
Steroid medication	Yes	No	Chemo / Radiation Treatment	Yes	No	Artificial Joints (knee, hips)	Yes	No
Kidney disease	Yes	No	Sexually transmitted disease	Yes	No	HIV/AIDS	Yes	No
Cold sores/fever blisters	Yes	No	Psychiatric care	Yes	No	Alcohol/drug abuse/rehab	Yes	No
Diabetes	Yes	No	Speech disorders/therapy	Yes	No	Heart murmur / MVP	Yes	No
Artificial heart valve	Yes	No	Pacemaker	Yes	No	Recent hospitalization	Yes	No
Reaction to anesthesia	Yes	No	Pain in jaw joints	Yes	No	Osteoporosis	Yes	No

I understand that the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge. If I ever have any change in my health or medications, I will inform the doctor at my next appointment. I also authorize and consent to X-Rays, study models, photographs, medications or any other diagnostic aids deemed necessary for treatment and diagnosis of my dental needs.

Patient, Parent, or Responsible Party's Signature_____ Date _____

Health History Reviewed By _____ Date _____

HIPPA ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I have reviewed a copy of this office's Notice of Privacy Practices:

(sign)_____ (date) _____

For Office Use Only

We attempted to obtain acknowledgement of receipt of Notice of Privacy Practices, but acknowledgement could not be obtained because:

Individual refused to sign: ___ Communications barriers prohibited obtaining the acknowledgement:___

An emergency situation prevented us from obtaining acknowledgement: ___

Other:_____