RICHARDSON PERIODONTICS & IMPLANT DENTISTRY

Personal Information:

Name: Mr., Mrs., Ms., Miss, Dr. _____ Age_____ Date of Birth_____
Social Security #:_____ Height_____ Weight_____
Home Address: _____ City_____ State_____ Zip_____
Mailing Address (if different): _____ City_____ State_____ Zip_____
Email Address: _____@_____ Phone# _____ Cell# _____
Circle one: employed/retired/student/non-employed
Employer: _____ Work# _____ Can we call you at work? (Y/N) _____
Work Address: _____ City_____ State____ Zip_____

Dental Insurance Information:

Insured Name: _____ Insured Social Security #: _____
Relation to Patient: Self/Spouse/Child/Other Insured's Date of Birth:_____ ID #_____
Group Plan Name:_____ Employer Name: _____
Carrier Name: _____ Group Number: _____

Dental History:

Current Dental Problem: _____
Referred By: _____ Are you currently in pain? (Y/N)_____
Have you ever been diagnosed with Periodontal Disease? (Y/N) _____ If yes, when? _____
General Dentist's Name: _____ Date of last dental exam? _____
Previous dental experiences worth noting: _____

Medical History:

Are you currently under the care of a physician? (Y/N) _____ Date of last physical exam: _____
Physician's Name_____ Physician's Phone #:_____
Serious Illness or Hospitalized in the last 12 months? (Y/N) _____ Reason: _____
Allergic to Medications? (Y/N) _____ if yes, please list: _____
Do you use Tobacco? (Y/N) _____ If yes: Type: _____ How long? _____ Frequency _____
Do you take Antibiotics prior to your dental appointments? (Yes/No) _____ Reason: _____
Do you take Anticoagulants (blood thinners)? (Y/N)_____ If yes, which ones? _____
Do you take drugs for Osteoporosis or Osteopenia? (Y/N) _____ If yes, which ones? _____

Please circle yes or no to the following medical questions or conditions:

Are you in overall good health?	Yes	No		Stomach Problems?	Yes	No
Heart Trouble? Murmur? M.V.P.?	Yes	No		Heartburn, GERD, Acid Reflux?	Yes	No
High Blood Pressure?	Yes	No		Cardiovascular Disease?	Yes	No
Stroke? Mini-Stroke? T.I.A.?	Yes	No		Bleeding Disorder? Anemia?	Yes	No
C.O.P.D.?	Yes	No		Cancer, Radiation, Chemotherapy?	Yes	No
Asthma?	Yes	No		Artificial Joints? Pins?	Yes	No
Emphysema?	Yes	No		Hepatitis, HIV, AIDS, other S.T.D.?	Yes	No
Seasonal Allergies	Yes	No		Osteoporosis or Osteopenia?	Yes	No
Kidney Problems? Dialysis?	Yes	No		Diabetes?	Yes	No
Liver Problems? Jaundice?	Yes	No		Epilepsy or Seizure Disorder?	Yes	No
Thyroid Problems?	Yes	No		Organ Transplant?	Yes	No
Latex Allergy? Material Allergy?	Yes	No		Tuberculosis?	Yes	No
Artificial Heart Valve?	Yes	No		Artery Stents?	Yes	No
Females Only: Are you pregnant?	Yes	No		Other condition not listed?	Yes	No

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I also acknowledge receipt of Richardson Periodontics and Implant Dentistry's notice of privacy practices.

_____

Signature of Patient (or legal guardian) ***Date***

Please list any medications you are currently taking:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

RICHARDSON
PERIODONTICS &
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Permission to Release Information to Dental and Non-Dental Persons.

Please list any family members (including spouse), friends, home health personnel or dentist that you authorize to receive information on your dental condition (e.g. appointments, proposed, pending, and completed treatment) or billing and/or insurance information. This information may be sent through traditional or electronic mail.

I, _____ give Richardson Periodontics & Implant Dentistry (Joseph P. Richardson D.M.D., M.S. and staff) permission to release dental/billing information to the following people.

Name: _____ Relationship: General Dentist Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

I, _____ wish the following persons to be contacted in an emergency:

Name: _____ Relationship: _____ Phone: _____

_____ _____

Patient or Guardian Signature Date

RICHARDSON
PERIODONTICS &
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Please review the following list of medications closely. This is a list of medications called **Bisphosphonates.** These medications are a class of drugs that prevent the loss of bone density, used to treat osteoporosis, osteopenia and similar diseases. These medications can have dental implications that should be discussed during today's appointment.

Do you take or have you ever taken:

Fosamax (Alendronate)	YES	NO	DATE of last dose_____
Actonel (Risedronate)	YES	NO	DATE of last dose_____
Boniva (Ibandronate)	YES	NO	DATE of last dose_____
Aredia (Pamidronate	YES	NO	DATE of last dose_____
Zometa (Zoledronic)	YES	NO	DATE of last dose_____
Reclast (Zoledronic)	YES	NO	DATE of last dose_____
Prolia (denosumab)	YES	NO	DATE of last dose_____
Evenity (romosozumab)	YES	NO	DATE of last dose_____
Binosto (Alendronate)	YES	NO	DATE of last dose_____

Any other prescribed bisphosphonate you may have been <u>prescribed</u> not on this list.

Signature _____ Date _____

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: Patient Giving Consent

Name: _____ **Phone**: _____

Address: _____

Section B: To the Patient – Please Read the Following Statement Carefully

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

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign the Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting: **Joseph P. Richardson D.M.D., M.S., P.A.** **2101 S. Bay Street Eustis, FL 32726**
352-589-1973 **RichardsonPeriodontics@Gmail.com**

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on the Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out our treatment, payment activities, and health care operations.

Signature: _____ **Date**: _____

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

Personal Representative's Name: _____ Relationship to patient: _____

YOU ARE ENTITILED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Revocation of Consent: I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ **Date:** _____

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First Visit:

We ask that you pay for your first visit. A receipt will be provided to you. If you have insurance, we will file your insurance for you for reimbursement. For your convenience, we accept Master Card, Visa, Discover, personal checks and cash.

Consultation:

After your examination, the doctor will diagnose his findings and set a treatment plan. This information is covered in detail with you during a consultation visit with Dr. Richardson.

Treatment:

After your consultation, we will be happy to process your insurance to determine what portion of your treatment fees your insurance benefits will provide. We do our utmost to work with you so that you may receive the maximum yearly insurance benefits. Please provide us with your complete and current dental insurance information so that we can file your claims promptly and correctly.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor, and is not a substitute for payment. After the pre-treatment estimate is received from the insurance company, we will ask you to pay your estimated portion of charges at each visit. We will file your claims for you while in active treatment.

Your pre-determination is an estimate of benefits and subject to variables (deductibles, other claims, etc.), and it is the patient's and responsible party's obligation to pay any balance not paid by your insurance company.

A repeat billing charge of $5.00 will be added to accounts more than 60 days old and additional interest fees will be levied at the rate of 1.5% on all unpaid balances over 90 days, unless other arrangements for regular monthly payments are made in advanced. If collection efforts become necessary, the responsible party will be liable for all costs and fees associated therewith, including attorney, fees.

_____ _____

Patient or Responsible Party Signature Date