NobelPerio®
Practice Limited to
Periodontics with Services in Implants/Oral Medicine

PATIENT INFORMATION

Name: _____ Date: _____ Sex: M or F
Last *First* *M.I.*

Birthdate: _____ SSN: _____ Please Circle: Single / Married / Divorced / Widowed

Address: _____
Street *City* *State* *Zip*

Home Phone: (_____) _____ Work Phone: (_____) _____ Cell: (_____) _____

Email Address: _____

Occupation: _____ Employer: _____

Spouse's Name: _____ Spouse's Work Phone: _____

Emergency Contact: _____ Relationship: _____ Phone Number: _____

Who is your General Dentist? _____ Whom may we thank for referring you? _____

HEALTH HISTORY

Physician: _____ Date of Last Visit: _____

Phone Number: (_____) _____

Please mark "Yes" or "No" to indicate if you have ever had any of the following:

Angina	❑ Yes ❑ No	Blood Disease	❑ Yes ❑ No	Thyroid: _____	❑ Yes ❑ No
Arteriosclerosis	❑ Yes ❑ No	Dizziness, Fainting	❑ Yes ❑ No	Arthritis / Rheumatism	❑ Yes ❑ No
Fibrillation	❑ Yes ❑ No	Epilepsy / Seizure	❑ Yes ❑ No	Joint Replacement (knee, hip, etc.)	❑ Yes ❑ No
Palpitations/Chest Pains	❑ Yes ❑ No	Headaches	❑ Yes ❑ No	Digestive Disorder	❑ Yes ❑ No
Heart Attack: Date: _____	❑ Yes ❑ No	Psychiatric Care	❑ Yes ❑ No	Liver Disease	❑ Yes ❑ No
Heart Defect	❑ Yes ❑ No	Vision / Hearing Impaired	❑ Yes ❑ No	Hepatitis, Type: _____	❑ Yes ❑ No
Heart Murmur/Leaky Valve	❑ Yes ❑ No	Asthma	❑ Yes ❑ No	Ulcer / Hyperactivity	❑ Yes ❑ No
High or Low Blood Pressure	❑ Yes ❑ No	Emphysema	❑ Yes ❑ No	Autoimmune / Immune Problem	❑ Yes ❑ No
Mitral Valve Prolapse/MVP	❑ Yes ❑ No	Shortness of Breath	❑ Yes ❑ No	Cancer: Type: _____	❑ Yes ❑ No
Pacemaker/Defibrillator	❑ Yes ❑ No	Sinus Infection	❑ Yes ❑ No	Kidney Disease	❑ Yes ❑ No
Rheumatic or Scarlet Fever	❑ Yes ❑ No	HIV / AIDS	❑ Yes ❑ No	Birth Control Pills	❑ Yes ❑ No
Stroke: Date: _____	❑ Yes ❑ No	Swollen Glands - neck	❑ Yes ❑ No	Nursing? _____	❑ Yes ❑ No
Valve Replacement	❑ Yes ❑ No	Tuberculosis	❑ Yes ❑ No	Pregnant Due: _____	❑ Yes ❑ No
Abnormal Bleeding	❑ Yes ❑ No	Herpes	❑ Yes ❑ No	Other: _____	❑ Yes ❑ No
Leukemia/Lymphoma	❑ Yes ❑ No	Diabetes: Type: _____	❑ Yes ❑ No		

Have you been told you need to PREMEDICATE or take antibiotics prior to a dental procedure? ❑ YES or ❑ NO

Which antibiotic did you take? _____ For what condition? _____

Please list any other medical concerns/conditions we should know about:

MEDICATIONS
List all medication you are currently taking

_____
_____
_____
_____
_____
_____
_____
_____

ALLERGIES
Check YES if you are allergic to:

Aspirin	❑ Yes ❑ No
Codeine/Other Narcotics	❑ Yes ❑ No
Iodine	❑ Yes ❑ No
Latex	❑ Yes ❑ No
Penicillin	❑ Yes ❑ No
Sulfa	❑ Yes ❑ No
Other Antibiotics: _____	❑ Yes ❑ No
Other: _____	❑ Yes ❑ No

SURGERY
List ALL past surgery, major and minor

_____
_____
_____
_____
_____
_____

Do you use Tobacco? _____ ❑ Yes ❑ No
How Often? _____

I certify that I have read and understand the above. I have received a copy of NobelPerio Notice of Privacy Practices. I acknowlege that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or ommissions that I may have madein the completion of this form.

_____ _____
Signature of Patient **Date** **Reviewing Doctor** **Date**

PLEASE COMPLETE THE OTHER SIDE OF FORM IF YOU HAVE DENTAL INSURANCE*

RESPONSIBLE PARTY INFORMATION

Responsible Party: _____ Relationship to Patient: _____

Address: _____
Street *City* *State* *Zip*

Phone: (_____) _____ Birthdate: ____/____/____

_____
Signature of Responsible Party *Date*

DENTAL INSURANCE INFORMATION

Name of Insured: _____ Relationship to Patient: _____

Insured's Birthdate: ____/____/____ SSN #: ____-____-____ Work Phone: (_____) _____

Employer: _____

Insurance Company: _____ Group #: _____ ID #: _____

Ins. Co. Address: _____
Street *City* *State* *Zip*

Do you have additional insurance? ❑ YES or ❑ NO If yes, please complete the following:

Name of Insured: _____ Relationship to Patient: _____

Insured's Birthdate: ____/____/____ SSN #: ____-____-____ Work Phone: (_____) _____

Employer: _____

Insurance Company: _____ Group #: _____ ID #: _____

Ins. Co. Address: _____
Street *City* *State* *Zip*

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I have insurance coverage as stated above, and assign directly to NobelPerio all insurance benefits, if any, otherwise payable to me for services rendered. I understand I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signaturs on all insurance submissions.

_____
Responsible Party Signature **Date**