Thank you for choosing our office to assist you with your dental needs.

Please fill out the information below and don't forget to provide your signature at the end.

Patient's name _____ **Date of Birth** _____

Sex: Female Male Decline to answer

If minor, name of legal guardian_____

Home phone _____ **Mobile phone** _____ **Work phone**_____

Mailing address _____ **City** _____

State _____ **Zip** _____ **Email address:**_____

Employer _____

Dental INSURANCE INFORMATION: insurance company_____

Your SS# : _____ **Member ID#**_____ **Group number**_____

Covered by spouse's insurance? ❑ yes ❑ no

Spouse's Name _____ **Employer**_____

Spouse's dental insurance company _____ **Group number** _____

Spouse's birthday _____ **SS#**_____ **Member ID#** _____

MEDICAL HEALTH HISTORY

Do you have, or have you had any of the following? (Please check any that apply)

❑ **Are you required to Pre-medicate before any dental treatment?**

❑ Blood Problems (Anemia)
❑ Blood transfusion
❑ Heart problems
❑ Heart murmur, mitral valve prolapse, heart defect
❑ Heart Pacemaker
❑ Stroke
❑ Bone or joint problems
❑ Artificial joint or valves
❑ High or low blood pressure (circle one)
❑ Tuberculosis or other lung problems
❑ Kidney disease
❑ Hepatitis, jaundice or other liver disease
❑ Diabetes TYPE 1 or TYPE 2
❑ Epilepsy or Neurological disorders
❑ Thyroid problems
❑ Arthritis
❑ Herpes or cold sores
❑ AIDS or HIV positive
❑ Cancer/Tumor
❑ Abnormal bleeding after any surgery (heavy bleeder)
❑ Hayfever or sinus trouble
❑ Allergies
❑ Asthma

Are you allergic to, or have you reacted adversely to any of the following?

❑ Latex
❑ Penicillin or other antibiotics
❑ Local anesthetics
❑ Codeine or other narcotics
❑ Sulfa drugs
❑ Barbiturates, sedatives, or sleeping pills
❑ Aspirin
❑ Other:_____

Are you taking any of the following?

❑ Aspirin
❑ Anticoagulants (blood thinners e.g. Coumadin)
❑ Antibiotics or sulfa drugs
❑ High blood pressure medicine
❑ Antidepressants or tranquilizers
❑ Insulin other diabetes drugs
❑ Nitroglycerin
❑ Cortisone or other steroids
❑ Osteoporosis (bone density) medicine
❑ Natural supplements
❑

Other:_____

Women:

❑ Are your pregnant or plant to become pregnant
❑ Taking hormones or contraceptives

Do you smoke,vape or use tobacco? ❑ yes ❑no

Signature of patient:_____ Date:_____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I acknowledge I reviewed a copy of the Cambridge Periodontics Notice or Privacy.
I give Cambridge Periodontics permission to send nonencrypted emails containing only xrays and treatment plan details to insurance companies and other dentists.

Patient Name_____

Signature_____ Date_____

For Guardian/Surrogate/Parent, I _____ represent that I am the representative for the patient above.

Representative's Signature_____

CAMBRIDGE PERIODONTICS

Payment:

Payment is expected for treatment when it is given.

Insurance:

Insurance policies are contracts between you, the subscriber, and the company. The doctor can in no way alter the contract nor guarantee you payment by the company. **AS A COURTESY TO YOU,** we will submit your dental insurance forms. We do not have control over when we will received reimbursement form them, or the amount of coverage that either yourself or employer has contracted.

We do our best to get the most accurate co-payment amount due, but there is no guarantee of payment until the check has been received by the insurance company,

Appointment Cancellation Policy Agreement:

Cambridge Periodontics is committed to proving all or our patients with exceptional care. Missed appointments impede our ability of offer exceptional dental care to our patients.

Please call the office by 11:00 a.m. on the day prior to your scheduled appointment to notify us of any changes or cancellations. **To cancel a *Monday* appointment, please call our office by 11:00 a.m. on *Friday*.** If prior notification is not given, you will be charged $100 for the missed appointment.

Please sign below to consent to these terms.

_____ _____

Signature (Parent/Guardian if under 18) Date