Macon M. Singletary DDS, MS
Diplomate in Periodontology

PATIENT REGISTRATION FORM

Patient Information

Name _____

Date of Birth_____ Age _____ Sex **M F** Marital Status **S M W D**

Address_____

City _____ State_____ Zip _____

Email Address _____ Cell Phone_____

Home Phone _____ Work Phone_____

Employer Name _____ SS# _____ Occupation _____

Name of Spouse_____ Employer _____ Phone _____

Is this visit the result of an injury? ❑ Yes ❑ No

If yes, what was the injury? _____

_____

Emergency Contact_____ Phone_____

Dental History

Referred by _____ City_____

Name of Dentist _____ City_____

How long have you been with your previous dentist? _____

How often were your teeth cleaned last year? _____

When was the last time your teeth were cleaned? _____

Have you ever been given a local anesthetic for dental cleanings?_____

PLEASE CIRCLE

Have you or anyone in your family had any previous periodontal treatment? ..... **YES NO**

By Whom? _____

Have you had any complication with previous dental treatment? ..... **YES NO**

Do you consider yourself a nervous person when it comes to dental treatment? ..... **YES NO**

Do you feel you have bad breath? ..... **YES NO**

Do your gums bleed?. ..... **YES NO**

Have you noticed any loose teeth? If yes, how long? ..... **YES NO**

Do you think your teeth are affecting your general health in any way? ..... **YES NO**

Are you satisfied with the appearance of your teeth? ..... **YES NO**

Do you have any sensitive teeth? ..... **YES NO**

Do you have any suggestions on how we could make your periodontal treatment less stressful and more comfortable for you?_____

_____

_____

_____

7805 Fiesta Way
Raleigh, NC 27615
T 919.518.8222 **F** 919.518.8252
www.northraleighperio.com

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Medical History

PLEASE PROVIDE SIGNED INSURANCE FORMS

Please complete this portion *only if you have dental insurance* as this will help us with submission of your insurance form.

Primary Dental Insurance Carrier _____

Subscriber's Name _____ _____
Last First Middle Date of Birth

Address _____

City _____ State_____ Zip _____

Home Phone _____ Work Phone_____

Employer Name _____ Subscriber's ID # _____Group Number _____

Insurance Carrier Name_____ Insurance Carrier Address _____

Please inform the Doctor if your health changes in any way

The success of periodontal therapy is dependent on many factors including the severity of the periodontal destruction, the patient's general physical status, and the patient's ability and willingness to perform proper oral hygiene and stay on a recall program after active treatment. As with treatment of any complex condition, especially where drugs and surgical procedures are being used, unusual and unanticipated problems can arise, such as bleeding, prolonged numbness, sensitivity to medications, sensitive or loose teeth and pulp damage. We will make every effort to keep you informed of the treatment necessary for you. Feel free to ask questions at any time. Your involvement and understanding are very important in the long term success of your periodontal therapy.

In implant surgery the potential risks and complications involved could include pain, swelling, infection, and discoloration. Numbness of the lip, tongue, chin, cheek, or tooth may occur. The exact duration may not be determinable and may be irreversible. Also possible are inflammation, injury to teeth, bleeding, bone fractures, sinus infection, and delayed healing. In some instances, implants fail and must be removed.

If there is any further information that you feel we should be aware of please write it here.

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PLEASE CIRCLE YES OR NO WHERE REQUESTED

Medical History

Name of Physician _____ City _____ Phone _____
Name of Physician _____ City _____ Phone _____
Date of last physical examination? _____ Findings _____
What is your estimation of your general health? ❑ Good ❑ Fair ❑ Poor
Do you smoke? **YES NO** How much? _____ How many years? _____ Have you ever smoked? **YES NO**
Has anyone in your family had diabetes? **YES NO**
Have you had surgery or x-ray treatment for a tumor, growth, or other condition of your head, mouth, or lips? **YES NO**
Are you now under the care of a physician? **YES NO**
Have you ever had any serious illness or major operations? **YES NO**
Have you had abnormal bleeding associated with previous surgery, tooth extraction, or trauma? **YES NO**
Are you taking or have you taken any drugs within the past year (tranquilizers, steroids, aspirin)? **YES NO**
If so, please list drug names and why you are taking them? (Attach list if necessary) _____

_____

_____

Have you ever been diagnosed with osteoporosis, or taken any bone altering/preserving medications (oral or IV)? **YES NO**
Do you routinely take natural/herb medications or supplements? **YES NO**
Are you allergic or have you had any adverse reaction to any of the following:

- Dental anesthetics (Novocaine, etc.) **YES NO**
- Penicillin, Tetracycline or other antibiotics **YES NO**
- Aspirin **YES NO**
- Codeine, Percodan, or other narcotics **YES NO**
- Valium or tranquilizers **YES NO**
- Anti-inflammatory drugs **YES NO**
- Nitrous Oxide Sedation (Laughing Gas) **YES NO**
- Other drugs (please list name(s) of drug(s) below) **YES NO**

_____

Have you ever been warned against taking any drug or medicine for your own personal health? **YES NO**
If so, what drug and why? _____
Are you routinely pre-medicated with an antibiotic for a dental procedure? **YES NO**
Have you ever had Sleep Apnea or used a C-PAP machine? **YES NO**

_____

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PLEASE CIRCLE YES OR NO WHERE REQUESTED

Medical History

Do you or have you had any of the following conditions:

Heart (Surgery Disease Attack)	YES	NO	Tuberculosis	YES	NO
Chest Pain	YES	NO	Asthma	YES	NO
Congenital Heart Disease	YES	NO	Hay Fever	YES	NO
Heart Murmur	YES	NO	Latex Sensitivity	YES	NO
High Blood Pressure	YES	NO	Allergies or Hives	YES	NO
High Cholesterol	YES	NO	Sinus Trouble	YES	NO
Mitral Valve Prolapse	YES	NO	Radiation Therapy	YES	NO
Artificial Heart Valve	YES	NO	Chemotherapy	YES	NO
Heart Pacemaker	YES	NO	Tumors	YES	NO
Rheumatic Fever	YES	NO	Hepatitis A (infectious) B (serum)	YES	NO
Arthritis/Rheumatism	YES	NO	Venereal Disease	YES	NO
Cortisone Medicine	YES	NO	A.I.D.S.	YES	NO
Swollen Ankles	YES	NO	H.I.V. Positive	YES	NO
Stroke	YES	NO	Cold Sores/Fever Blisters	YES	NO
Diet (Special/Restricted)	YES	NO	Blood Transfusion	YES	NO
Artificial Joints (hip knee. etc.)	YES	NO	Hemophilia	YES	NO
Kidney Trouble	YES	NO	Sickle Cell Disease	YES	NO
Osteoporosis	YES	NO	Bruise Easily	YES	NO
Ulcers	YES	NO	Liver Disease	YES	NO
Diabetes I Last A1C.	YES	NO	Yellow Jaundice	YES	NO
Thyroid Problems	YES	NO	Neurological Disorders	YES	NO
Glaucoma	YES	NO	Epilepsy or Seizures	YES	NO
Contact lenses	YES	NO	Fainting or Dizzy Spells	YES	NO
Emphysema	YES	NO	Nervous/Anxious	YES	NO
Chronic Cough	YES	NO	Psychiatric/Psychological Core	YES	NO

FOR WOMEN ONLY

Are you taking female hormones (oral contraceptives, etc.)? **YES NO**
Are you pregnant at the present time? **YES NO**
If so, month of delivery **YES NO**
Are you planning on becoming pregnant in the near future? **YES NO**
Have you reached menopause? **YES NO**

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Acknowledgement of receipt of Notice of Privacy Practices

** You may refuse to sign this acknowledgment **

I _____ have received a copy of this office's Notice of Privacy Practices
Patient's Name

_____ _____ _____
Please Print Name Signature Date

FOR OFFICE USE ONLY

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

- ❑ Individual refused to sign
- ❑ Communication barriers prohibited obtaining the acknowledgement
- ❑ An emergency situation prevented us from obtaining acknowledgement
- ❑ Other (Please Specify) _____

_____

_____

_____ _____
Witness/Office Agent Date

Consent for Treatment

1. I hereby authorize North Raleigh Periodontics or designated staff to take x-rays, study models, photographs and any other diag nostic aids deemed appropriate by our office to make a thorough diagnosis of (name of patient) _____'s dental needs.
2. Upon such diagnosis, I authorize North Raleigh Periodontics to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics, sedatives, and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
4. Lastly, I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% late charge (18% APR) may be added to my account.

Patient Signature _____ Date_____

Parent or Responsible Party_____ Relationship to Patient_____

We want to thank you for taking the time to fill out this questionaire for us!