



**Macon M. Singletary DDS, MS**

Diplomate in Periodontology

NorthRaleighPerio.com

**North Raleigh Periodontocs**

Macon M. Singletary DDS, MS

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## Welcome to North Raleigh Periodontics

First Name \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ ZIP \_\_\_\_\_

Phone: Home \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_ ☎ \_\_\_\_\_

Email \_\_\_\_\_ Age \_\_\_\_\_ Birthdate \_\_\_\_\_ Sex \_\_\_\_\_

SSN \_\_\_\_\_ Is this visit the result of an injury? \_\_\_\_\_

If yes, what was the injury? \_\_\_\_\_

Referral Dentist & Practice \_\_\_\_\_

How long have you been with your current dentist? \_\_\_\_\_ Last dental cleaning? \_\_\_\_\_

How often were your teeth cleaned last year? \_\_\_\_\_

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

List any previous periodontal treatment & doctor \_\_\_\_\_

Have you had any complications with previous dental treatment? circle Y N

Do you consider yourself a nervous person with dental treatment? Y N

Do you think your teeth are affecting your general health in any way? Y N

Are you satisfied with the appearance of your teeth? Y N

Have you noticed any loose teeth? Y N

Do you feel you have bad breath? Y N

Do you have any sensitive teeth? Y N

## Pharmacy & Medication Information

PHARMACY \_\_\_\_\_ Street/Phone \_\_\_\_\_

Medical Physician/Practice \_\_\_\_\_ Phone \_\_\_\_\_

Date of last physical exam? \_\_\_\_\_ General health status (circle) good fair poor

List all medications & supplements you are currently taking, including premedications

\_\_\_\_\_

\_\_\_\_\_

### Are you ALLERGIC or have an adverse reaction to any of the following?

Dental anesthetics (Novocaine, Lidocaine, Marcaine) Y N Aspirin Y N

Codeine, Percodan or other narcotics Y N Anti-inflammatory: Aleve, Ibuprofen Y N

Vallium, Xanax, Ativan or tranquilizers Y N Nitrous Oxide - Laughing Gas Y N

Antibiotics \_\_\_\_\_

List medications you have been advised against taking for health reasons \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Medical History

Do you SMOKE or VAPE (circle)? How much? \_\_\_\_\_ How many years? \_\_\_\_\_ Have you ever smoked? Y N  
Have you been diagnosed with osteoporosis or taken bone altering/preserving medications (oral or IV)? Y N  
Have you had abnormal bleeding associated with previous surgery, tooth extraction, or trauma? Y N  
Have you had surgery or x-ray for a tumor or growth on your head, mouth, or lips? Y N  
Are you routinely pre-medicated with an antibiotic for a dental procedure? Y N  
Are you now under the care of a physician? Y N Have you been diagnosed with SLEEP APNEA? Y N  
Do you or anyone in your family have diabetes? Y N Do you use a CPAP machine? Y N  
Do you drink alcoholic beverages? Y N Do you snore loudly? Y N  
**List any serious/major operations you have had.** Are you often tired or sleepy during the day? Y N

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Do you have any of the following conditions? ✓

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> A.I.D.S.                  | <input type="checkbox"/> Diet (Special/Restricted) | <input type="checkbox"/> Nervous/Anxious                 |
| <input type="checkbox"/> Allergies or Hives        | <input type="checkbox"/> Epilepsy or Seizures      | <input type="checkbox"/> Neurological Disorders          |
| <input type="checkbox"/> Arthritis                 | <input type="checkbox"/> Fainting or Dizzy         | <input type="checkbox"/> Osteoporosis                    |
| <input type="checkbox"/> Artificial Heart          | <input type="checkbox"/> Glaucoma                  | <input type="checkbox"/> Psychiatric/Psychological       |
| <input type="checkbox"/> Artificial Joints         | <input type="checkbox"/> Heart Attack              | <input type="checkbox"/> Radiation Therapy               |
| <input type="checkbox"/> Asthma                    | <input type="checkbox"/> Heart Disease             | <input type="checkbox"/> Rheumatic Fever                 |
| <input type="checkbox"/> Blood Transfusion         | <input type="checkbox"/> Heart Surgery             | <input type="checkbox"/> Sickle Cell Disease             |
| <input type="checkbox"/> Bruise Easily             | <input type="checkbox"/> Heart Pacemaker           | <input type="checkbox"/> Sinus Trouble                   |
| <input type="checkbox"/> Cancer (past or pres)     | <input type="checkbox"/> Hemophilia                | <input type="checkbox"/> Sleep Apnea                     |
| <input type="checkbox"/> Chemotherapy              | <input type="checkbox"/> Hepatitis A or B          | <input type="checkbox"/> Stroke                          |
| <input type="checkbox"/> Chest Pain                | <input type="checkbox"/> High Blood Pressure       | <input type="checkbox"/> Smoking / Vaping (past or pres) |
| <input type="checkbox"/> Chronic Cough             | <input type="checkbox"/> High Cholesterol          | <input type="checkbox"/> Swollen Ankles                  |
| <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> H.I.V Positive            | <input type="checkbox"/> Thyroid Disease                 |
| <input type="checkbox"/> Congenital Heart Disease  | <input type="checkbox"/> Kidney Trouble            | <input type="checkbox"/> Tuberculosis                    |
| <input type="checkbox"/> Contact Lenses            | <input type="checkbox"/> Latex Sensitivity         | <input type="checkbox"/> Tumors                          |
| <input type="checkbox"/> COPD                      | <input type="checkbox"/> Liver Disease             | <input type="checkbox"/> Ulcers                          |
| <input type="checkbox"/> Cortisone Medicine        | <input type="checkbox"/> Mitral Valve              | <input type="checkbox"/> Venereal Disease                |
| <input type="checkbox"/> Diabetes I Last A1C       |  | <input type="checkbox"/> Yellow Jaundice                 |

### Women

- I am pregnant Month due \_\_\_\_\_
- I am planning to become pregnant in the near future
- I am taking female hormones / contraceptives
- I have reached MENOPAUSE

**Please inform the doctor if there is any additional information we should be aware of.**

## Insurance

We file all dental insurance on your behalf, however, the patient is responsible for payment of their account. Full payment is expected for all charges.

Primary Dental Insurance \_\_\_\_\_ Group # \_\_\_\_\_

Insurance Address \_\_\_\_\_ Phone# \_\_\_\_\_

Subscribers Name \_\_\_\_\_ Subscriber Birthdate \_\_\_\_\_

Subscriber Employer \_\_\_\_\_ Subscriber ID# \_\_\_\_\_

## Please Inform the Doctor

The success of periodontal therapy is dependent on many factors including the severity of the periodontal destruction, the patient's general physical health 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 as your involvement and understanding are very important to the long term success of your periodontal therapy.

With 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. [Please advise us of any additional information that would be helpful with your treatment.](#)

## Consent for Treatment

I hereby authorize North Raleigh Periodontics and designated staff to take x-rays, study models, photographs and any other diagnostic aids deemed appropriate by this office to make a thorough diagnosis for my treatment.

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.

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.

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 1-1.5% late charge (18% APR) may be added to my account.

I acknowledge that I have read and consent to the [Notice of Privacy Practices, Appointment Change Policy, Consent for Treatment](#) and [Payment Policy](#).

Print Patient Name \_\_\_\_\_

Signature of parent or responsible party

\_\_\_\_\_ Date \_\_\_\_\_