Macon M. Singletary DDS, MS
Diplomate in Periodontology
NorthRaleighPerio.com

North Raleigh Periodontics
Macon M. Singletary DDS, MS
7805 Fiesta Way Raleigh, NC 27615
☎ 919.518.8222 919.518.8252

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_____
Have you previously had scaling and root planing (also known as deep cleaning) with anesthetic? If so, when?_____
List any previous periodontal treatment & doctor_____
General health status (circle) good fair poor

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 _____

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 - Lauging Gas	Y N
Antibiotics	Y N	Other_____	

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

Have you been diagnosed with SLEEP APNEA? Y N
Do you use a CPAP machine? Y N
Do you snore loudly? Y N
Are you often tired or sleepy during the day? Y N

List any serious/major illnesses or operations you have had in the past 6 months.

_____

Do you have any of the following conditions? ✓

- Acid Reflux/GERD
- A.I.D.S.
- Allergies or Hives
- Arthritis
- Artificial Heart
- Artificial Joints
- Asthma
- Bad Breath
- Blood Transfusion
- Bruise Easily
- Cancer (past or pres)
- Chemotherapy
- Chest Pain
- Chronic Cough
- Cold Sores/Fever Blisters
- Congenital Heart Disease
- COPD
- Depression
- Diabetes I Last A1C
- Epilepsy or Seizures
- Fainting or Dizzy
- Fibromyalgia
- Glaucoma
- Heart Attack
- Heart Disease
- Heart Surgery
- Heart Pacemaker
- Hemophilia
- Hepatitis A or B
- High Blood Pressure
- High Cholesterol
- H.I.V Positive
- Kidney Trouble
- Latex Sensitivity
- Liver Disease
- Mitral Valve
- Nervous/Anxious
- Neurological Disorders
- Osteoporosis
- Periodontal Disease
- Psychiatric/Psychological
- Radiation Therapy
- Rheumatic Fever
- Sickle Cell Disease
- Sinus Trouble
- Sleep Apnea
- Stroke
- Smoking / Vaping (past or pres)
- Swollen Ankles
- Thyroid Disease
- Tuberculosis
- Tumors
- Ulcers
- Venereal Disease
- 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.

Occasionally we use patients' intra-oral photos (photos that are taken of your teeth, gums, and oral tissue) on our social media. Do we have your permission to use or share your photos on our social media platforms?

☐ YES ☐ NO

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_____