IMPrESS Perio Implant Center

DR. MEHDI NOROOZI, DDS, MSc, Dip. Perio, FRCD(C), DABP
DR. NATHALIE PAULETTO, DMD, MSc, Dip. Perio
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Unit 304 - 1901 Rosser Avenue, Burnaby, BC V5C 6R6
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PATIENT INFORMATION

Email: _____

Name (Miss, Mrs., Ms., Mr., Dr.) _____ Date of Birth _____
Age _____
SURNAME GIVEN NAMES

Address _____ Cellular _____

City _____ Postal Code _____ Home Phone _____

Employer _____ Occupation _____

Business Address _____ Business Phone _____

Name of Spouse _____

Family Dentist _____ Phone _____

Family Physician _____ Phone _____

Referred By _____ Phone _____

Whom should we contact in the event of an emergency: _____ Phone _____

Do you have dental insurance? ☐Yes ☐No

Name of insurance carrier _____ Group Policy/Contract Number _____

Name of Subscriber _____ Subscriber's Date of Birth _____

Identity / Certificate / SIN # _____ Dependent Code _____

Employer Name _____ % Coverage: Plan A/Basic _____

Do you have two insurance plans? ☐Yes ☐No IF YES, please give details on second plan:

Name of insurance carrier _____ Group Policy/Contract Number _____

Name of Subscriber _____ Subscriber's Date of Birth _____

Identity / Certificate / SIN # _____ Dependent Code _____

Employer Name _____ % Coverage: Plan A/Basic _____

MEDICAL HISTORY

The following information is required to thoroughly diagnose any condition, and to give the highest possible standard of professional services. All information will be kept strictly confidential.

☐Yes ☐No 1. Are you now under the care of a physician? If so, what is the condition being treated?

_____

☐Yes ☐No 2. Have you had any serious illness or operation? If so, what was the illness of operation?

_____

☐Yes ☐No 3. Have you ever been hospitalized? If so, what was the problem?

_____

☐Yes ☐No 4. Are you taking any drugs or medicine? If so, please list them:

_____

☐Yes ☐No 5. Are you allergic or have you reacted adversely to any drug or medicine: e.g. local anaesthetic (freezing); Penicillin or other antibiotics; barbiturates, sedatives, analgesics (pain killers)? If so, please list them:

6. Do you have or have you had any of the following diseases or problems?

☐Yes ☐ No (a) Rheumatic fever or rheumatic heart disease?

☐Yes ☐No (b) Congenital heart disease?

☐Yes ☐No (c) Cardiovascular disease: e.g. heart trouble; heart attack; high blood pressure; arteriosclerosis (hardening of the arteries); stroke?

☐Yes ☐No (d) Chest pains or shortness of breath?

☐Yes ☐No (e) Asthma, hay fever, skin rash?

☐Yes ☐No (f) Fainting spells or seizures: e.g. (epilepsy)?

☐Yes ☐No (g) Diabetes?

☐Yes ☐No (h) Kidney disease?

☐Yes ☐No (i) Hepatitis, jaundice or liver disease?

☐Yes ☐No (j) Endocrine disorder: e.g. thyroid disease?

☐Yes ☐No (k) Lung or breathing disorders: e.g. tuberculosis?

☐Yes ☐No (l) Gastrointestinal disease: e.g. ulcers?

☐Yes ☐No (m) Nervous disorder?

☐Yes ☐No (n) Bone, muscle or joint disorders: e.g. arthritis?

☐Yes ☐No (o) Cancer?

☐Yes ☐No (p) Heart murmur?

☐Yes ☐No (q) Radiotherapy?

☐Yes ☐No (r) Prosthetic joints or valves?

☐Yes ☐No (s) Venereal disease or AIDS?

☐Yes ☐No 7. Have you ever had abnormal bleeding associated with previous extractions, surgery, or trauma?
Do you bruise easily? _____

☐Yes ☐No 8. Do you have any blood disorder?

☐Yes ☐No 9. Women – are you pregnant? Which month of pregnancy? _____

☐Yes ☐No 10. Do you have any disease or problem not listed above you think I should know about?
If yes, please explain.
_____

☐Yes ☐No 11. Do you smoke? If so, how much? _____

12. What dental condition concerns you at present? _____

☐Yes ☐No 13. Are you <u>currently</u> or <u>have you ever</u> taken biphosphonate drugs or osteoporosis medications?

I BELIEVE THE INFORMATION ON THIS FORM TO BE CORRECT AND TO PROVIDE A COMPLETE SUMMARY OF MY PAST OR PRESENT MEDICAL AND DENTAL STATUS.

I HAVE HAD AN OPPORTUNITY TO REVIEW THE OFFICE POLICY STATEMENT.

I, the undersigned (patient or legally responsible party), authorize dental treatment to be rendered by the Dentist and his staff, and assume financial responsibility for all charges not covered or paid to the dentist by any third party carrier.

Signature _____ DATE _____

DATE	B.P.	PULSE	RESP.	M.H. CHANGES

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FOR THE INFORMATION OF OUR PATIENTS

Our office provides specialized dental care for referred patients. The clinic environment, the materials and the techniques we offer are very different than those from most general dental practices. The business nature of our office may also differ from what you are used to with your family dentist. Please review the following points to ensure that you are comfortable with our **office management policies.**

Insurance Payments:

Our office will assist you in receiving the maximum insurance benefit appropriate for your treatment while under care. **However, we do not accept payment directly from dental insurance companies.** You will be asked to personally manage the professional fee for your dental care and we will manage both the insurance pre-determination and the claims on your behalf. Your insurance company will probably refund you directly, usually based upon a percentage of the general dentists' customary fee for standard care. Please be aware that dental insurance benefits are most frequently set according to average cost for regular treatment in a family practice. Any dispute arising from treatment rendered will be adjudicated by the province in which the service is provided.

Appointment Reservation:

Our receptionist will reserve the most convenient appointment times possible for you and will also provide you with a confirmation card. It is our patient's responsibility to be conscientious about attending scheduled visits as agreed upon when they are booked. If an appointment time must be changed, we require a **minimum** of **three business days notice or more pending on the length of the appointment reserved for you.** This allows our receptionist time to offer your reserved time to another patient. If we are not given sufficient notice, we will charge a fee for the missed visit. This charge will range from **$108 or more,** depending upon the length of the appointment. There is no dental insurance coverage for this.

Routine Dental Care:

Please remember that your **routine dental care for caries control and other restorative needs as well as polishing of teeth and/or scaling are still provided on a regular basis, annually or semi annually**, at your dentist's office as per their recommendation. Please contact your dentist's office directly to schedule these visits as needed during your periodontal therapy in our office.

Photographs and other diagnostic records will be taken as part of your initial records. These records may be used for teaching purposes or for other professional use.

We appreciate your taking a moment to familiarize yourself with the above management details. Please indicate your acknowledgment of these points by signing on the space below.

Signature_____ **Date**_____

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Questionaire

Last Dentist Name & phone number:

Periodontist in the past?

Periodontal Treatment in the past?

Last periodontal cleaning:
Local anesthesia used?

Frequency of dental cleanings per year:

Last radiograph x-rays:

Chief concern:

Bleeding when brushing teeth/gums?

Concerned about appearance of teeth/gums?

Oral Hygiene - Brushing how many times per day:
Technique:

Flossing how many times per day:

Habits - Occlusion/Bite:
Jaw problems?

Signature_____ **Date**_____