GRANITE STATE PERIODONTICS

PAMELA Z. BALDASSARRE, DMD
PRACTICE LIMITED TO PERIODONTICS

HEALTH QUESTIONNAIRE

ALL INFORMATION WILL BE HELD IN STRICT CONFIDENCE

Patient's Name: Date:

Dentist's Name: Phone Number

Physician's Name: Phone Number

Date of Last Physical:

Many medical problems can affect your periodontal health even though they seem unrelated to you. Please answer the following as accurately as possible. Include over the counter medications and supplements.

Have you ever had or do you have any of the following?			**Explain/Comment any YES answers**
Rheumatic Fever	No	Yes	
Heart Trouble	No	Yes	
Heart Murmur	No	Yes	
Heart Arrhythmia/ Irregular Beat	No	Yes	
Heart Valve Replacement	No	Yes	
Heart Attack	No	Yes	date
Chest Pain/Angina	No	Yes	
Cardiac Pacemaker	No	Yes	
Cardiac Stent/ Graft	No	Yes	
Heart Surgery	No	Yes	
Bruise Easily	No	Yes	
High Blood Pressure	No	Yes	
Have you taken PHEN PHEN?	No	Yes	
Bleeding Problem	No	Yes	
Fainting Spells	No	Yes	
Blood Transfusion	No	Yes	
Anemia	No	Yes	
Diabetes	No	Yes	
Digestive Disease/ Crohn's Disease	No	Yes	
Asthma	No	Yes	
Sleep Apnea	No	Yes	

Do you have a prosthetic joint/implant	No	Yes	
Arthritis	No	Yes	Describe:
Osteoporosis	No	Yes	
Osteopenia	No	Yes	
Osteonecrosis	No	Yes	
Cancer, Radiation Therapy or Chemotherapy	No	Yes	
A tumor or growth	No	Yes	
Problems with immune system	No	Yes	
Thyroid Problems	No	Yes	
Problem with drug or alcohol abuse?	No	Yes	
Anxiety	No	Yes	
Depression	No	Yes	
Lung Trouble	No	Yes	
Do you smoke?	No	Yes	
Tuberculosis	No	Yes	
Hepatitis Type_____	No	Yes	
AIDS/HIV	No	Yes	
COVID-19	No	Yes	
Epilepsy	No	Yes	
Concussion	No	Yes	
TMJ Problem or pain	No	Yes	
General Anesthesia	No	Yes	

Are you ALLERGIC to the Following, Please List ALL other ALLERGIES and ADVERSE reactions below:

❑ Penicillin	❑ Adverse reaction to **epinephrine "rapid heartbeat with novocaine"**
❑ Erythromycin	
❑ Sulfa drugs	❑ Latex allergy
❑ Codeine	❑ Other:
❑ Other	❑

CURRENT MEDICATIONS:

*Please list all medications you may be taking, including herbal supplements (i.e.: Gingko Biloba) and over the counter medications such as **aspirin and nonsteroidal anti-inflammatory:***

Are you taking blood thinners?	Yes/ No	Steroids?	Yes/No	Bisphosphonates?	Yes/ No

List Additional Medications: OR provide typewritten list to attach

Have you ever been hospitalized? **When** **Why**

Have you ever had any serious illnesses or injuries?

Do you have a cold or bronchitis?

Have you been under a physician's care within the past five years? **Yes** **No**

If so, why?

FEMALES:			**Date of last complete Dental Exam:**
Are you pregnant?	**Yes**	**No**	**Frequency of Dental Exams:**
Are you taking birth control pills?	**Yes**	**No**	**How often do you clean your teeth?**
DENTAL HISTORY:			**What type of brush do you use?**
Have you ever had periodontal treatment?	**Yes**	**No**	**Do you floss?** **How often?**

Is it important to you that you keep your teeth for a very long time? How would you feel if you had to have dentures

Please describe the reason you were referred to me:

*Signature and Date:*_____

PATIENT INFORMATION & FINANCIAL AGREEMENT *Date:* _____

Pamela Z. Baldassarre, D.M.D. Practice Limited to Periodontology

Patient Name: Dr/Mr/Mrs/Ms/Miss

Address:

City *State:* *ZipCode:*

Home Phone: ( ) *Work Phone: ( )* *ext:_____*

Cell Phone ( ) *Email Address:*

APPOINTMENTS ARE CONFIRMED ELECTRONICALLY. PLEASE PROVIDE THE ABOVE INFORMATION – THIS INFORMATION WILL NOT BE USED BY OUTSIDE SOURCES.

Birthdate: *SSN:* *Nickname:*

Referring Dentist *Physician:*

Person to contact in emergency: *Phone*

_____

Guarantor of Account:

AUTHORIZATION & RELEASE

_____ *I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me, or my child, during the period of such dental care to third party payers and/or other health practitioners.*

FINANCIAL AGREEMENT

**Your dental plan may cover only part of your dental treatment, if any. It is understood that you are responsible for the entire balance on your account. As a courtesy, there is no charge for submitting your dental claim; however, any dispute on fees is between you and your insurance carrier.*

_____ I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me

_____ I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependent's.

_____ I understand that verbal and written predetermination of benefits are not a guarantee of payment.

_____ I understand that a $75 cancellation fee MAY be applied for cancellations without 48 hours' notice.

Signature: _____ Date: _____

Print Name: _____

Primary DENTAL INSURANCE INFORMATION

Plan Description:

(Ins. Co.) Address:

Insured Party: *DOB:*

Insured Party ID: *Insured Party SSN:*

Employer Name:

Group No: *Group Name:*

Policy Start Date: *Policy End Date*

Deductible Met: *Annual Maximum:*

Secondary DENTAL INSURANCE INFORMATION

Plan Description:

(Ins. Co.)Address:

Insured Party: *DOB:*

Insured Party ID: *Insured Party SSN*

Employer Name:

Group No: *Group Name:*

Policy Start Date *Policy End Date:*

Deductible Met: *Annual Maximum:*

PLEASE PROVIDE US WITH CURRENT COPIES OF YOUR MEDICAL AND DENTAL INSURANCE CARDS

RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgement*

I, _____, have received a copy of this office's Notice of Privacy Practices.

I give permission for Dr. Baldassarre's office to e-mail treatment information to my healthcare providers. The e-mail communications are sent SECURE/ENCRYPTED.

If you would like us to share your treatment information with any other person, please list their name(s) (e.g. spouse, parent) _____

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)