PERIODONTAL ASSOCIATES
OF EASTERN IOWA

Welcome to Our Practice

Please fill out this form as completely as you can. If you have any questions, we will be glad to help you. We look forward to working with you in maintaining your dental health.

Name_____Soc. Sec.#_____
Last Name First Name Initial

Address_____

City_____State_____Zip_____

Cell Phone_____Home Phone_____

Sex ☐M ☐F Birthdate_____/_____/_____ ☐Single ☐Married ☐Widowed ☐Divorced

Email Address_____

Patient Employed By_____Occupation_____

Business Address_____Phone_____

In case of emergency, please notify_____

Relationship_____Phone_____

Preferred Pharmacy_____

DENTAL INSURANCE

Policy Holder_____ Employer_____

Relationship_____Phone_____ Insurance Co._____

Birthdate_____SS#_____ ID#_____Group#_____

Address_____ Insurance Co Address_____

_____ _____

I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits, or to communicate with my referring dentist.

I authorize the office to contact me via e-email, phone call, or text messages regarding my care and/or appointment reminders.

I, the undersigned, hereby agree to the following terms. All past due accounts are subject to a finance charge of 1.5% per month or maximum rate allowed by law. If, at any time, or for any reason, the undersigned is unable to pay for services when due, the undersigned agrees to pay and authorize Periodontal Associates to bill their account finance charges as described above. I agree to be personally responsible for all charges, if at any time, or any reason, the undersigned is unable to pay as agreed and in the event it becomes necessary for Periodontal Associates to incur collection costs or institute suit to collect any amount due under this agreement, the undersigned promises to be responsible for all charges incurred, and agrees to pay collection fees and expenses, including reasonable attorneys' fees and court costs plus, all legal fees if incurred for collection. The undersigned submits to jurisdiction and venue of Johnson, Linn, or Henry County, IA.

Signature_____Date_____

PATIENT INFORMATION

Welcome to our office! To assist us in serving you, please complete the following confidential form. The information provided is important to your dental health.

Patient name _____ Preferred name _____ Birth date_____

MEDICAL HEALTH HISTORY

Do you have or have you had any of the following?
(Please check ALL that apply)

- ☐ Cancer or tumor
- ☐ Heart ailment or angina (chest pain)
- ☐ Heart murmur, mitral valve prolapse, heart defect
- ☐ Heart valve surgery/replacement
- ☐ Rheumatic fever or rheumatic heart disease
- ☐ Artificial joint
  Date of joint replacement_____
- ☐ Endocarditis
- ☐ Stroke
- ☐ High or low blood pressure
- ☐ Pacemaker
- ☐ Tuberculosis or other lung problems
- ☐ Kidney disease
- ☐ Hepatitis or other liver disease
- ☐ Alcoholism
- ☐ Blood transfusion
- ☐ Diabetes
- ☐ Thyroid disease
- ☐ Ulcer
- ☐ Neurologic condition
- ☐ Epilepsy, seizures, or fainting spells
- ☐ Emotional condition
- ☐ Arthritis
- ☐ Herpes or cold sores
- ☐ AIDS or HIV positive
- ☐ Migraine headaches or frequent headaches
- ☐ Glaucoma
- ☐ Anemia
- ☐ Hemophilia
- ☐ Any other blood disorder not previously mentioned
- ☐ Abnormal bleeding after extractions, surgery, or trauma
- ☐ Hay fever or sinus trouble
- ☐ Allergies or hives
- ☐ Asthma

Do you consume alcohol? ☐yes ☐no

If yes, how many drinks/week?_____

Do you smoke or vape? ☐yes ☐no

If yes, how much?_____

Do you use chewing tobacco? ☐yes ☐no

If yes, how much?_____

Do you have a history of tobacco use? ☐yes ☐no

Are you allergic to, or have you reacted adversely to any of the following?

- ☐ Latex materials
- ☐ Penicillin
- ☐ Other antibiotics _____
- ☐ Local anesthetics ("Novocaine")
- ☐ Codeine or other narcotics_____
- ☐ Sulfa drugs
- ☐ Barbiturates, sedatives, or sleeping pills
- ☐ Aspirin
- ☐ Other:_____

Are you taking or have you EVER taken any of the following?

- ☐ Aspirin
- ☐ Anticoagulants (blood thinners)
- ☐ Nitroglycerin
- ☐ Cortisone or other steroids (prednisone, etc)
- ☐ Osteoporosis (bone density) medicine(oral or IV)
- ☐ Radiation treatment
- ☐ Chemotherapy treatment

Women:

- ☐ Pregnant or trying to become pregnant
  Expected delivery date: _____
- ☐ Taking hormones
- ☐ Taking contraceptives

Name of physician _____

Names of any medical specialists seen _____

Any medical conditions not listed above _____

Please list **ALL** medications, vitamins, or supplements you are currently taking. If you do not take anything, please check the box below.

_____ _____

_____ _____

_____ _____

_____ _____

☐ I do **not** take **any** medications, vitamins, or supplements

Dental History

Reason for visit today: _____ Referred by: _____

Date of last dental cleaning: _____

How often do you brush? _____ How often do you floss? _____

Do you have dental pain or concerns? If so, describe: _____

_____

Please add anything else you would like us to know about: _____

Signature of patient _____ Date _____

Signature of parent or guardian (if applicable) _____ Date _____

Relationship to patient _____

Consent for Purposes of Treatment, Payment, and Healthcare Operations

I consent to the use or disclosure of my protected health information by the office of Periodontal Associates of Eastern Iowa, PLLC for the purpose of diagnosing or providing treatment to me, obtaining payment for my dental health care bills, or treatment of me by the office of Periodontal Associates of Eastern Iowa, PLLC may be conditioned upon my consent as evidence by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. The office of Periodontal Associates of Eastern Iowa, PLLC is not required to agree to the restrictions that I may request. However, if the office of Periodontal Associates of Eastern Iowa, PLLC agrees to a restriction that I request, the restriction is binding on the office of Periodontal Associates of Eastern Iowa, PLLC.

I have the right to revoke this consent, in writing, at any time, except to the extent that the office of Periodontal Associates of Eastern Iowa, PLLC has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my dentist, another health care provider, a health or dental plan, my employer or a dental care clearinghouse. This protected health information relates to my past, present, or future dental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review the practice's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of healthcare operations of Periodontal Associates of Eastern Iowa, PLLC. The Notice of Privacy Practices is posted at the reception desk. This Notice of Privacy Practices also describes my rights and the duties of Periodontal Associates of Eastern Iowa, PLLC with respect to my protected health information.

Periodontal Associates of Eastern Iowa, PLLC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy to be sent in the mail, or asking for one at the time of my next appointment.

Please list anyone who you allow access to your dental & medical records, not including your providers.

Name:_____Relationship to patient:_____

_____ _____

Printed Name of Patient or Personal Representative Date

_____

Signature of Patient or Personal Representative

PERIODONTAL ASSOCIATES
OF EASTERN IOWA

No Show/ Late Cancellation Policy Agreement

We schedule our appointments so that each patient receives the right amount of time to be seen by our providers and staff. It is for this reason that it is very important that you keep your scheduled appointment with us, and arrive on time.

As a courtesy, and to help patients remember their scheduled appointments, Periodontal Associates sends reminder calls and/or text messages 72-96 hours in advance of our patient appointments. If your schedule changes and you cannot keep your appointment, please contact our office so we may reschedule your appointment, and accommodate those patients who are on a waiting list. We ask that you please give us more than 48 hours' notice of cancellation/reschedule as a courtesy to our other patients who could be seen in a canceled appointment slot as well as to our providers and staff.

If you do not cancel or reschedule your appointment with at least 48 hours' notice, we reserve the right to assess a nonrefundable fee prior to rescheduling.

Surgeries: $200.00
Scaling and Root Planings: $100.00
Consults, Follow-ups, and other appointments: $57.00

After three consecutive "no-shows" and/or "late cancellations", we reserve the right to decline to make future appointments with you.

Please sign below to acknowledge to Periodontal Associates' policy. Thank you.

_____

Signature Date