Periodontal Health Professionals
of Southern New Jersey
NJ Specialty Permit LIC. # 3446

Gail Gerard Childers, D.M.D., P.A.

Practice Limited to
Periodontics Dental Implantology

Patient Name _____ **Date** _____

Email _____

Health Questionnaire

Medical History

In the following questions, circle yes or no, which ever applies.
Your answers are for our records only and will be considered confidential.

1. Has there been any change in your general health within the last year? ..... YES NO
2. My last physical examination was on _____
3. Are you now under the care of a physician? ..... YES NO
   a. If so, what is the condition being treated? _____
4. The name and address of my physician is _____
   Phone Number ( ) _____
5. Have you had any serious illness or operation? ..... YES NO
   If so, what was the illness or operation? _____
6. Have you been hospitalized or had a serious illness within the last five (5) years? ..... YES NO
7. Do you have or have you had any of the following diseases or problems? ..... YES NO
   a. Rheumatic fever or rheumatic heart disease (heart murmur) ..... YES NO
   b. Congenital heart lesions ..... YES NO
   c. Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, coronary, occlusion, high blood pressure, arteriosclerosis, stroke) ..... YES NO
      1) Do you have any pain in chest upon exertion? ..... YES NO
      2) Are you ever short of breath after mild exercise? ..... YES NO
      3) Do your ankles swell? ..... YES NO
      4) Do you get short of breath when you lie dawn, or do you require extra pillows when you sleep? ..... YES NO
   d. Bypass surgery or prosthetic valves, hips, etc. ..... YES NO
   e. Allergy ..... YES NO
   f. Sinus trouble ..... YES NO
   g. Asthma or hay fever ..... YES NO
   h. Hives or a skin rash ..... YES NO
   i. Fainting spells ..... YES NO
   j. Diabetes ..... YES NO
      1) Do you have to urinate (pass water) more than six times a day? ..... YES NO
      2) Are you thirsty much of the time? ..... YES NO
      3) Does your mouth frequently become dry? ..... YES NO
   k. Hepatitis, jaundice or liver disease ..... YES NO
   l. Herpes (fever blisters) ..... YES NO
   m. Arthritis ..... YES NO
   n. Inflammatory rheumatism (painful swollen joints) ..... YES NO
   o. Stomach ulcers ..... YES NO
   p. Kidney trouble ..... YES NO
   q. Tuberculosis ..... YES NO
   r. Do you have a persistent cough or cough up blood? ..... YES NO
   s. Low blood pressure ..... YES NO
   t. Venereal Disease ..... YES NO
   u. Other _____
8. Have you had abnormal bleeding associated with previous extractions, surgery or trauma? ..... YES NO
   a. Do you bruise easily? ..... YES NO
   b. Have you ever required a blood transfusion? ..... YES NO
   c. If so, explain the circumstances _____
   _____

Health Questionnaire

Medical History

9. Do you have any blood disorder such as anemia? ..... YES NO
10. Have you had any surgery or x-ray treatment for a tumor, growth, or other condition of your mouth or lips ..... YES NO
11. Are you taking any drug or medicine? ..... YES NO
    If so, what? _____
12. Are you taking any of the following:
    a. Antibiotics or sulfa drugs ..... YES NO
    b. Anticoagulants (blood thinners) ..... YES NO
    c. Medicine for high blood pressure ..... YES NO
    d. Cortisone (steroids) ..... YES NO
    e. Tranquilizers ..... YES NO
    f. Antihistamines ..... YES NO
    g. Aspirin ..... YES NO
    h. Insulin, tolbutamide (Orinase) or similar drug ..... YES NO
    i. Digitalis or drugs for heart trouble ..... YES NO
    j. Nitroglycerin ..... YES NO
    k. Other _____
13. Are you allergic or have you reacted adversely to:
    a. Latex ..... YES NO
    b. Local anesthetics ..... YES NO
    c. Penicillin or other antibiotics ..... YES NO
    d. Sulfa drugs ..... YES NO
    e. Barbiturates, sedatives, or sleeping pills ..... YES NO
    f. Aspirin ..... YES NO
    g. Iodine ..... YES NO
    h. Codeine or other narcotics ..... YES NO
    i. Other _____
14. Have you ever had any serious trouble associated with any previous dental treatment? ..... YES NO
    If so, explain _____
15. Do you have any disease, condition, or problem not listed above that you think I should know about? ..... YES NO
    If so, explain _____
    _____
16. Are you employed in any situation which exposes you regularly to x-rays or other ionizing radiation? ..... YES NO
17. Are you wearing contact lenses? ..... YES NO
18. Have you ever been exposed to or are a carrier of the HIV (AIDS) related complex? ..... YES NO
19. Do you presently smoke or have you ever in the past? ..... YES NO

WOMEN

20. Are you pregnant? ..... YES NO
21. Do you have any problems associated with your menstrual period? ..... YES NO

Future Medical History Update

Date	Findings
Date	Findings
Date	Findings

_____ _____

Signature of Patient *Date*

Patient Information

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Date _____

A. General Information

1. Patient Name *Last* *First* *Middle*

2. Home Address *Street*

City *State* *Zip*

3. Social Security # **Date of Birth**

4. Home Phone **Physician**

5. Referring Dentist

6. Person Financially Responsible for Account *Name* *Relationship to Patient*

Phone *Fax* *Social Security #*

7. Billing Address *Street*

City *State* *Zip*

B. Employment Information

Employed by **Occupation**

Address *Street*

City *State* *Zip*

Phone *Fax*

C. Primary Dental Insurance information for processing claims

Co-pays are due at the time of service.

Insured's Name

Social Security # **Date of Birth**

Insurance Company Name

Group Plan Name or Number

Employer Name

Insurance Identification Number

Home Address of Insured *Street*

City *State* *Zip*

Phone

Second Dental Insurance information for processing claims

As a courtesy we will process your secondary claim. All balances are due in full and you will be reimbursed directly through your secondary insurance company.

Insured's Name

Social Security # **Date of Birth**

Insurance Company Name

Group Plan Name or Number

Employer Name

Insurance Identification Number

Home Address of Insured *Street*

City *State* *Zip*

Phone

D. Emergency Contact

Name **Phone**

E. Remarks

How did you hear about us? (please check)

O Yellow Pages O Friend/Relative O Referral O Other _____

Please complete Consent for Treatment form on opposite side.

Patient Information

Consent For Treatment

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) _____'s dental needs.

2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. 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.

4. 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 1/2% late charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.

_____

Patient's Signature Date Witness

_____

Parent/Responsible Party's Signature Relationship to Patient