PATIENT INFORMATION RECORD

The following information is needed for our records. Please print answers to all questions.

PATIENT'S NAME _____ PREFERRED NAME_____ GENDER _____
First Middle Init. Last Male/Female

Birth Date _____ Age _____ Marital Status _____ Social Security No. _____

Home Phone _____ Cell Phone _____ Email Address _____

Home Address _____
Street City/State/Zip

PATIENT EMPLOYER _____ Bus. Phone _____

Employer Address _____
City/State/Zip

NAME OF SPOUSE _____ Birth Date _____

Spouse Employer_____ Bus. Phone _____

Employer Address _____
City/State/Zip

Name of parent or guardian if patient is a minor _____ Parent or Guardian Employer_____

Address if different from patient's_____

INSURANCE INFORMATION

Dental Insurance Company _____

Mailing Address _____

Name of Subscriber (Self, Spouse or Parent) _____

General Dentist _____ Phone _____

Physician _____ Phone _____

Physician Address _____

Who referred you to our office? _____

ACKNOWLEDGEMENT OF 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.

_____
(Please Print Name)

_____
Patient Signature (or Parent/Guardian if minor) Date

I give permission to Trammell Periodontics to disclose and release my protected health information described below to:

Name(s): **Relationship:**

_____ _____
_____ _____
_____ _____

Health Information to be disclosed (Check all that apply):

_____ My complete dental record (including but not limited to dental/medical history, diagnoses, lab tests, prognosis, treatment and billing, for all conditions).

_____ OR My complete health record, as above, with the exception of the following information:
_____

This authorization shall be effective until (Check one):

____ All past, present, and future periods

____ Date or event:_____ unless I revoke it. (NOTE: You may revoke this authorization in writing at any time by notifying Trammell Periodontics, preferably in writing.)

_____
(Please Print Name)

_____
Patient Signature (or Parent/Guardian if minor) Date

Trammell Periodontics, LLC

Patient Name: Birth Date:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	Yes No	If yes
Have you ever been hospitalized or had a major operation?	Yes No	If yes
Have you ever had a serious head or neck injury?	Yes No	If yes
Are you taking any medications, pills, or drugs?	Yes No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	Yes No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	If yes
Are you on a special diet?	Yes No	
Do you use tobacco?	Yes No	

Women: Are you...

Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin	Penicillin	Codeine	Acrylic
Metal	Latex	Sulfa Drugs	Local Anesthetics

Other? If yes

Do you use controlled substances? Yes No If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive Yes No	Cortisone Medicine Yes No	Hemophilia Yes No	Radiation Treatments Yes No
Alzheimer's Disease Yes No	Diabetes Yes No	Hepatitis A Yes No	Recent Weight Loss Yes No
Anaphylaxis Yes No	Drug Addiction Yes No	Hepatitis B or C Yes No	Renal Dialysis Yes No
Anemia Yes No	Easily Winded Yes No	Herpes Yes No	Rheumatic Fever Yes No
Angina Yes No	Emphysema Yes No	High Blood Pressure Yes No	Rheumatism Yes No
Arthritis/Gout Yes No	Epilepsy or Seizures Yes No	High Cholesterol Yes No	Scarlet Fever Yes No
Artificial Heart Valve Yes No	Excessive Bleeding Yes No	Hives or Rash Yes No	Shingles Yes No
Artificial Joint Yes No	Excessive Thirst Yes No	Hypoglycemia Yes No	Sickle Cell Disease Yes No
Asthma Yes No	Fainting Spells/Dizziness Yes No	Irregular Heartbeat Yes No	Sinus Trouble Yes No
Blood Disease Yes No	Frequent Cough Yes No	Kidney Problems Yes No	Spina Bifida Yes No
Blood Transfusion Yes No	Frequent Diarrhea Yes No	Leukemia Yes No	Stomach/Intestinal Disease Yes No
Breathing Problems Yes No	Frequent Headaches Yes No	Liver Disease Yes No	Stroke Yes No
Bruise Easily Yes No	Genital Herpes Yes No	Low Blood Pressure Yes No	Swelling of Limbs Yes No
Cancer Yes No	Glaucoma Yes No	Lung Disease Yes No	Thyroid Disease Yes No
Chemotherapy Yes No	Hay Fever Yes No	Mitral Valve Prolapse Yes No	Tonsillitis Yes No
Chest Pains Yes No	Heart Attack/Failure Yes No	Osteoporosis Yes No	Tuberculosis Yes No
Cold Sores/Fever Blisters Yes No	Heart Murmur Yes No	Pain in Jaw Joints Yes No	Tumors or Growths Yes No
Congenital Heart Disorder Yes No	Heart Pacemaker Yes No	Parathyroid Disease Yes No	Ulcers Yes No
Convulsions Yes No	Heart Trouble/Disease Yes No	Psychiatric Care Yes No	Venereal Disease Yes No
			Yellow Jaundice Yes No

Have you ever had any serious illness not listed Yes No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____

Trammell Periodontics
Medication List

If you are taking any prescribed medications, OTC medications, herbal supplements or vitamins, please complete this form.

My Name is: _____

My Healthcare Provider's Name is: _____

My Healthcare Provider's Phone Number is: _____

I am currently taking the following:

Medication	When I take it	Dose	Other Instructions

☐ I have no medications to list at this time.

TRAMMELL PERIODONTICS PATIENT AGREEMENT

We are committed to providing you with the best possible care. In order to achieve these goals, we ask for your assistance and understanding of our financial and scheduling policies.

Financial Policy:

- Payment for services rendered is due and payable at the time of treatment. We accept Cash, Check, Visa or Mastercard.
- We have an agreement with CareCredit® patient financing, a third party financing company, which may afford you the opportunity to make monthly payments for your treatment. CareCredit® offers low interest plans to qualified applicants. Please inquire if you are interested in applying.
- Minor Children: The parent or guardian that brings a minor child in for treatment in our practice is responsible for payment for services.
- Administrative Fees and Interest: There is a $30 service charge for returned checks. Account balances that are 30 days or more past due are subject to 1½% monthly interest (18% annual percentage rate (APR)).
- Past due balances owed are subject to interest and collection practices of this office and to the maximum extent allowable by the State of Alabama.

Appointment Policy:

- We do not double-book appointments in our office, and request 3 business days' notice for all cancellations of appointments. Broken appointments or late cancellations of appointments with less than 24 hours' notice are subject to a fee of 10% of the total planned appointment cost with a minimum of $50.
- A $75.00 fee will be charged for any Late Cancellation or No Show periodontal maintenance appointments with the hygienist. We reserve the right to charge for any appointment(s) broken without 48 hours notice. These fees are not covered by insurance and are the sole responsibility of the patient. Fees must be paid in full prior to the patient's next appointment. Habitual missed/ cancelled/rescheduled appointments may result in a patient being required to pay up front prior to scheduling an appointment.

Dental Insurance:

- Dental insurance amounts are estimated coverage only; the estimated patient share of fees is required at the time of service. The patient/responsible guardian is responsible for amounts not covered by insurance or claims not paid within 60 days from date of service.
- If you have any questions about the above information or any uncertainty regarding insurance coverage, please don't hesitate to ask us. We are here to help you.

Dental Insurance Signature on File:

I hereby authorize payment of the insurance benefits otherwise payable to me directly to Trammell Periodontics.

_____ _____

Signature Date

Acknowledgement & Agreement to Pay:

I have been informed of Trammell Periodontics financial and appointment policies. I agree to be responsible for all fees incurred during the course of my treatment. I understand that the responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I, the undersigned, accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all collection agency fees (33.33%), attorney fees and/or court costs, if such be necessary.

_____ _____

Signature of Patient or Responsible Party Date

Express prior consent to contact consumer by cell phone. You agree, in order for us to service your account or to collect monies you may owe, Trammell Periodontics, LLC and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable.

I have read this disclosure and agree that Trammell Periodontics, its employees and/or agents may contact me as described above.

_____ _____

Signature of Patient or Responsible Party Date