GARY F. BERNARD, DDS, PLLC

Limited to Periodontics & Dental Implants

Pima Medical Pavillion
8415 N. Pima Rd., Suite 250
Scottsdale, AZ 85258

Ph 480-948-7000
Fax 480-948-7531
www.BernardPerio.com

PATIENT INFORMATION

Mr. Mrs. Ms. Miss. Dr. | Patient Name | Today's Date

Address:

City State Zip | Email Address:

Home Phone | Work Phone | Cell Phone

Gender (M F) | Marital Status (M S D W) | Date of Birth | Social Security

Employed By | Occupation

Name of Spouse | Date of Birth | Social Security

Employed By | Occupation

Do you have an additional permanent address: ☐ Yes ☐ No

General Dentist | Phone Number (if known)

Whom may we thank for referring you?

PRIMARY DENTAL INSURANCE

Primary Policy Holder | Date of Birth | ID Number

Employer providing insurance | Insurance Company Name

Insurance Company Address | Insurance Company Phone Number

SECONDARY DENTAL INSURANCE

Secondary Policy Holder | Date of Birth | ID Number

Employer providing insurance | Insurance Company Name

Insurance Company Address | Insurance Company Phone Number

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further agree and acknowledge that my signature on this document authorizes my dentist to submit claims for benefits and services rendered and that I will be bound by this signature as though the undersigned had personally signed this particular claim. I authorize payment for such services be made to the dentist named. I understand that I am responsible for all costs of dental treatment. I also understand and accept that should collection proceedings be instituted, attorney fees, collection expenses, interest and court costs will be imposed.

X Patient/Guardian Signature: Date:

PATIENT MEDICAL HISTORY

Patient Name:	Date of Birth:

Periodontal disease is caused by a combination of complex factors and successful treatment depends upon their identication.
The following questions are pertinent to the treatment of your periodontal condition.
IF YOU HAVE A HEART MURMUR, ARTIFICIAL HEART VALVE OR JOINT REPLACEMENTS,
YOU MAY NEED TO BE PREMEDICATED FOR ALL TREATMENTS, INCLUDING THE PERIODONTAL EXAMINATION.

Please answer ***ALL*** questions. Check **Yes or No**, whichever applies. All answers are confidential.

Y	N	CONDITIONS
☐	☐	Heart Surgery, Disease, or Attack
☐	☐	Chest Pain
☐	☐	Congenital Heart Defect
☐	☐	Heart Murmur
☐	☐	High Blood Pressure
☐	☐	Low Blood Pressure
☐	☐	Mitral Valve Prolapse
☐	☐	Artificial Heart Valve
☐	☐	Pace Maker
☐	☐	Rheumatic Fever
☐	☐	Arthritis/Rheumatism
☐	☐	Cortisone Medication
☐	☐	Swollen Ankles
☐	☐	Stroke
☐	☐	Diet (Special/Restricted)
☐	☐	Artificial Joints (hip, knee, etc)
☐	☐	Kidney Problems
☐	☐	Ulcers
☐	☐	Diabetes or Family History
☐	☐	Thyroid Problems
☐	☐	Glaucoma
☐	☐	Contact Lenses

Y	N	CONDITIONS
☐	☐	Emphysema
☐	☐	Chronic Cough
☐	☐	Tuberculosis
☐	☐	Asthma
☐	☐	Hay Fever/Allergy/Hives
☐	☐	Latex Sensitivity
☐	☐	Sinus Problems
☐	☐	Radiation Therapy
☐	☐	Cancer - Chemotherapy
☐	☐	Tumors
☐	☐	Hepatitis A B C (circle)
☐	☐	Venereal Disease
☐	☐	A.I.D.S. / H.I.V. Positive
☐	☐	Cold Sores/Fever Blisters
☐	☐	Blood Transfusion
☐	☐	Hemophilia
☐	☐	Sickle Cell Disease
☐	☐	Bruise Easily
☐	☐	Liver Disease/Yellow Jaundice
☐	☐	Neurological Disorders
☐	☐	Epilepsy or Seizures
☐	☐	Fainting or Dizzy Spells

Y	N	CONDITIONS
☐	☐	Nervous/Anxious
☐	☐	Psychiatric/Psychological Care
☐	☐	Tobacco Use
☐	☐	Alcohol Use
☐	☐	Other:

Y	N	ALLERGIES
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Dental Anesthetics
☐	☐	Erythromycin
☐	☐	Jewelry
☐	☐	Latex
☐	☐	Metals
☐	☐	Penicillin
☐	☐	Tetracycline
☐	☐	Other:

Y	N	PLEASE ANSWER IF FEMALE
☐	☐	Are you taking Birth Control Pills?
☐	☐	Are you pregnant? #_____of weeks
☐	☐	Are you nursing?

Medications:	Dosage:	Frequency:

Physician Name	Physician Phone
Pharmacy Phone:	Pharmacy Phone

Y	N	
☐	☐	**Is there any disease, condition, or problem that you think this office should know about that is not covered above?** If yes, please describe below.
☐	☐	**Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or other similar drugs?** If yes, please descibe below.

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

X Patient/Guardian Signature:	Date:

History Review:

Date	*Patient Signature*	*Dr/Hyg*	*Date*	*Patient Signature*	*Dr/Hyg*
Date	*Patient Signature*	*Dr/Hyg*	*Date*	*Patient Signature*	*Dr/Hyg*
Date	*Patient Signature*	*Dr/Hyg*	*Date*	*Patient Signature*	*Dr/Hyg*
Date	*Patient Signature*	*Dr/Hyg*	*Date*	*Patient Signature*	*Dr/Hyg*