ROBERT A. BURNS, JR., D.D.S.
Practice Limited to Periodontics

Patient's Name_____Home Phone_____Work Phone_____

Date of Birth_____Social Security#_____

Home Address_____City_____Zip _____

Business Name_____

Business Address_____City_____Zip _____

Spouse's Name_____Work Phone_____

Business Address_____City_____Zip _____

Referred by_____

Payment is due at the time services are rendered unless other arrangements have been previously made. Our office will file your insurance claims as a NO COST courtesy to you. This in no way implies that this office is responsible for collecting fees from the insurance company for services rendered. It is the sole responsibility of the patient or guardian of the patient to pay the fees for services rendered. We will assist you the best we can in understanding your insurance benefits based on the plan information you provide. Accounts over 90 days are subject to a 1.5% monthly finance charge.

If you are covered by Dental Insurance, please complete the section below:

PRIMARY
Name of Insurance Company_____Group or Policy Number_____

Name of Insured_____Social Security #of Insured_____

SECONDARY
Name of Insurance Company_____Group or Policy Number_____

Name of Insured_____Social Security # of Insured_____

AUTHORIZATION TO PAY BENEFITS TO DENTIST

I hereby authorize payment directly to the dentist of the insurance benefit otherwise payable to me for their services.

Signature_____

INFORMATION RELEASE

I hereby reviewed the treatment plan and authorize the release of any information relating to my treatment or pre-authorization including x-rays and periodontal charting.

Signature_____

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DENTAL HISTORY

YES NO Are you experiencing pain or swelling at this time?

YES NO Do your gums bleed when you brush or floss?

When was your last professional dental cleaning?_____

How often do you have your teeth cleaned?_____

YES NO Have you had any type of gum disease treatment?

When and by whom?_____

YES NO Have you noticed any loose teeth?

YES NO Do you have a history of gum disease in your family?

How often do you brush your teeth?_____

How often do you floss?_____

YES NO Have you ever worn braces? When?_____

YES NO Have you had your wisdom teeth extracted? How many?_____

YES NO Are you aware of clenching or grinding your teeth during the day or night?

YES NO Do you smoke? What and how much?_____

YES NO Do you experience frequent headaches? How often?_____

YES NO Do you have any dental phobias or history of extreme anxiety to dental treatment?

YES NO Have we treated any of your family or friends? Who?_____

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MEDICAL HISTORY

Today's Date_____

Name_____ Birthdate_____ Height_____ Weight_____

Physician's Name_____ Telephone_____

Please answer all questions by circling YES or NO and fill in any blanks. If you don't understand a question, consult Dr. Burns prior to your exam. All information is considered confidential.

1. Date of your last complete physical examination_____
2. Have you been hospitalized or had a serious illness within the last 3 years? ..... YES NO
   If so, for what problem?_____
3. Are you currently under the care of a physician? ..... YES NO
   If so, for what condition?_____
4. Do you have or have you had any of the following diseases or problems:

A. CARDIOVASCULAR:

1 Rheumatic Fever	YES	NO	7 Congestive Heart Failure - date _____	YES	NO
2 Congenital Heart Defect	YES	NO	8. Heart Surgery - type _____ date _____	YES	NO
3 Angina Pectoris (Chest Pain)	YES	NO	9. Pacemaker Implanted - date _____	YES	NO
4 Myocardial Infarction (Heart Attack)	YES	NO	10. High Blood Pressure - BP ____/____	YES	NO
5 Arrhythmias (Irregular Heart Beat)	YES	NO	11 Low Blood Pressure - BP ____/____	YES	NO
6 Heart Murmur - cause	YES	NO	12 Stroke (CVA) - date _____	YES	NO

B. RESPIRATORY DISEASES:

1 Asthma - severity _____	YES	NO
2 Emphysema - severity _____	YES	NO
3 Bronchitis - severity _____	YES	NO
4 Sinusitis or Hay Fever	YES	NO

C. ENDOCRINE DISORDERS:

1 Diabetes - type _____	YES	NO
2 High Thyroid - treatment _____	YES	NO
3 Low Thyroid - treatment _____	YES	NO

D. BLOOD DISORDERS:

1 Anemia - type _____	YES	NO
2 Do you bruise easily?	YES	NO

E. PSYCHIATRIC TREATMENT:

1 Have you received psychiatric treatment in the past 5 years? Physician _____	YES	NO

F. INFECTIOUS DISEASES:

1 Hepatitis - type _____ date _____	YES	NO
2 Tuberculosis - date _____	YES	NO
3 Venereal Disease - type _____ date _____	YES	NO
4 AIDS - Human Immunodeficiency Virus (HIV)	YES	NO

G. KIDNEY DISEASE:

1 Have you had a kidney infection in the past 3 years?	YES	NO
2 Have you had kidney surgery? Type _____ date _____	YES	NO

H. MISCELLANEOUS DISEASES OR DISORDERS:

1 Fainting - frequency _____	YES	NO	6 Radiation - type _____ date _____	YES	NO
2 Liver Disease - type _____	YES	NO	7 Epilepsy - treatment _____	YES	NO
3 Arthritis - type _____	YES	NO	8. Cancer - type _____ date _____	YES	NO
4 Ulcers - type _____	YES	NO	9. Use tobacco? - type _____	YES	NO
5 Glaucoma - type _____	YES	NO			

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5. ARE YOU TAKING ANY OF THE FOLLOWING MEDICATIONS?:

A. Antibiotics - type:_____dosage:_____ YES NO
B. Anticoagulants (Blood Thinners) - type._____ YES NO
C. Steroids (Cortisone) - type._____dosage:_____ YES NO
D. High Blood Pressure Medicine - type:_____ YES NO
E. Sedatives (Tranquilizers) - type:_____dosage:_____ YES NO
F. Aspirin - how often?._____ YES NO

Other Medications:

G. _____dosage:_____
H. _____dosage:_____
I. _____dosage:_____

6. ARE YOU ALLERGIC OR HAVE YOU HAD A REACTION TO:

A. Local Anesthetics - type:_____reaction:_____ YES NO
B. Penicillin - reaction:_____ YES NO
C. Other Antibiotics - type _____reaction._____ YES NO
D. Aspirin - reaction._____ YES NO
E. Pain Medicines - type._____reaction:_____ YES NO
F. Sedatives - type _____reaction:_____ YES NO

Other Medications

G _____reaction _____ YES NO

7. Do you have any problem or condition not listed above? YES NO

If so, explain:_____

8. WOMEN ONLY:

Are you pregnant? - delivery date _____ YES NO

9. SURGERY OR HOSPITALIZATION RECORD: (not recorded above)

Date _____Reason _____
Date _____Reason _____
Date _____Reason _____

I UNDERSTAND THE IMPORTANCE OF NOTIFYING MY DOCTOR OF ANY MEDICAL CHANGES UPON EACH VISIT.

Patient/Guardian Signature:_____Date:_____

_____Date _____ _____Date._____
_____Date _____ _____Date._____
_____Date _____ _____Date _____
_____Date _____ _____Date._____
_____Date _____ _____Date:_____