PERSONAL INFORMATION

Full Name: ______________________________ Preferred Name: _______________ Sex: M / F
Date of Birth: ____________ Age: ______ Marital Status: ____________ SSN: ______________
Address: ____________________________________ City, State: _____________________
Zip Code: ___________ Phone #: _______________ Email: ____________________________
Occupation: ______________________ How did you find us? ___________________________
Person Responsible for Payment: ___________________________ Relation: _____________
Emergency Contact: _______________ Relation: ___________ Phone #: _________________

MEDICAL HISTORY

Primary Care Physician: _________________________________ Ph #: _______________

Address: _______________________________ Last Physical Examination: ____________

Are you currently being treated? No / Yes – For what? _____________________________________

Have you ever had any surgical operations? No / Yes – For what? When? _____________________

If you have had joint replacements, heart stents and/or heart conditions, have you ever been told by your doctor to pre-medicate with antibiotics prior to any dental visits to protect you from infective endocarditis? Yes / No **If yes:** What antibiotic regimen?______________________________

Please check all that apply to you:

- ☐ ADD/ADHD
- ☐ AIDS/HIV
- ☐ Allergies and/or Hay fever
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bacterial Endocarditis
- ☐ Blood Thinners
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Bruise Easily
- ☐ Cataracts/Glaucoma
- ☐ Cancer or Tumor
- ☐ Diabetes – Type _____
- ☐ Difficulty swallowing
- ☐ Dry Mouth
- ☐ Ear, Nose, Throat Condition
- ☐ Epilepsy or seizures
- ☐ Fainting or dizzy spells
- ☐ Frequent or severe headaches
- ☐ Gastrointestinal Condition
- ☐ Hepatitis – Type _____
- ☐ Heart Disease/ Heart Problems
- ☐ Hormone Therapy
- ☐ Joint Replacement
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lupus
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Skin Conditions
- ☐ Stroke
- ☐ Shortness of breath
- ☐ Substance Abuse
- ☐ Tuberculosis
- ☐ Thyroid Dysfunction
- ☐ Ulcers
- ☐ Under abnormal stress
- ☐ Venereal Disease (Herpes, Syphilis, etc.)
- ☐ Neurological Disorder
- ☐ Psychiatric Disorder

☐ Smoker: Current / Former How long? __________ Quantity? __________ Quit Date: __________
☐ Taken Bisphosphonates (for bone loss): Type? ______________ How long? ________________
___Oral/Pill form OR ___Intravenous (IV)

Please explain further if you have checked any of the above and list any other conditions we should know about:

____

____

Reason for today's visit? ____

____

Females Only: Are you pregnant? Y / N Date of delivery? __________ Are you taking birth control pills? Y / N

Please list all medications you are currently taking and the reasons for taking them:

MEDICATIONS	**REASONS**
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

Please list all medication allergies as well as any other pertinent allergies:

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

DENTAL HISTORY

Dentist: ______________________ Address: ______________________________ Ph #: ______________

Frequency of Cleanings? ______________________ When was your last cleaning? ____________________

How often do you visit your dentist? ________________________ How often do you brush? _____________

How often do you floss? _____________ Do you want nitrous oxide (laughing gas) during treatment? Y / N

PREVIOUS PERIODONTAL THERAPY

Previous periodontal dentists and hygienists: ____

Have you ever had deep cleanings (scaling and root planing)? Y / N

When? ____________ Which areas? Full mouth / Upper right / Lower right / Upper left / Lower left

When did you first learn of your periodontal problem? ____________ Who informed you? _______________

Have you had periodontal surgery before? Y / N What was done and when? ___________________________

Who performed the surgery? _________________________

ARE YOU

- ☐ Allergic to dental anesthetics
- ☐ Slow in healing
- ☐ Wearing removable dental appliances
- ☐ Experiencing sore teeth
- ☐ Experiencing sensitivity to hot or cold
- ☐ Experiencing sensitivity to sweets
- ☐ Experiencing bleeding gums

DO YOU

- ☐ Have a fear of dental treatment
- ☐ Have prolonged bleeding after injury or tooth extraction
- ☐ Have pain in your jaw, face, head, neck, back, shoulders
- ☐ Hear noises in your jaw joints
- ☐ Clench or grind your teeth
- ☐ Have frequent headaches

HAVE YOU

- ☐ Ever had TMJ treatment
- ☐ Ever had orthodontic treatment
- ☐ Ever had someone adjust your bite or grind on your teeth
- ☐ Had shifting of any teeth

REVIEW OF MEDICAL HISTORY

Office Use Only

To the best of my knowledge, all the above answers are true and correct. If I have any changes in my health, I **will** inform Dr. Abdoney at my next appointment.

______________________	____________	______________________	____________
Signature	Date	Mark A. Abdoney, DMD	Date

Dental Insurance Information

We only file with dental insurance, NOT medical insurance

Patient Name: ______________________________

Policyholder: ______________________________

Date of Birth: ____________ **Relationship to patient:** ____________

Address if different than patient: ______________________________

Employer: ______________________________

Name of Dental Insurance Company: ______________________________

Phone #: ____________________

Member ID or SSN: ______________________________

Group #: ______________________________

I hereby instruct and direct the insurance company stated above to pay by check made out and mailed to:

Mark A. Abdoney, D.M.D.
Abdoney Periodontics and Implant Dentistry
2714 W. Azeele St.
Tampa, Florida 33609
Or

For the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services tendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay in a current manner, any balance of said professional service charges over and able this insurance payment.

A photocopy of this assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, or attorney involved in this case.

I authorize doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Dated: ____________________

Signature: ______________________________

No Dental Insurance / Self-Pay Consent For Payment

I will not be using dental insurance and am a self-pay patient. I understand that I am responsible for all charges incurred. I understand that by accepting to have treatment, it makes me responsible for all costs. I understand that Dr. Abdoney and staff will present treatment plan(s) and all possible scenarios, also understanding that sometimes there may be circumstances that can alter the treatment plan(s).

Dated: ____________________

Signature: ______________________________

HIPAA NOTICE OF PRIVACY PRACTICES

You can find our HIPAA Notice of Privacy Practices on the clipboard given to you to fill out your patient forms.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED, DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

You have the right and choice to share your health information with those you want involved in your care.

**Please list any family, close friends, or others involved in your care who you give permission to share your health information with along with providing appointment information and pre/post-operative instructions:*

Name(s): ____

We can use your health information and records to share with other professionals who are treating you. This includes the coordination and management of your care and treatment case with third party participants. Xrays and diagnostic photos are taken to thoroughly diagnose, monitor patient care, and treatment success. These diagnostic images may be used for dental lectures, articles, patient education, and website material. Diagnostic images used exclude the patient's name and/or similar identifying information. No full face pictures will be used without authorization. The use of patient images confers no rights of ownership or royalties.

Prior to dental procedures and some special prophylactic needs, prescriptions will be needed.
Please indicate the pharmacy of your choice

- ❏ Pharmacy Name:_________________________ Pharmacy Phone:____________________________

  Pharmacy Street Address: ____Zip Code:_____________

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties to privacy practices with respect to protected health information. If you have any objections to this form, please speak with Dr. Mark Abdoney in person or by phone at our main phone number. Signature below is only acknowledgment that you have received or reviewed this Notice of our Privacy Practice.

Print Name: ___________________________________

Signature: ____________________________________

Date: ____