

PerioCare Braden C. Seamons, DDS
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*The benefits of a happy, healthy smile are immeasurable!
 Our goal is to help you reach and maintain maximum oral
 health. Please fill out this form completely. The better we
 communicate, the better we can care for you.*

(This information is necessary for our records and is considered confidential)

PATIENT INFORMATION

Name= _____ Male Female Birthdate= _____
 Last First Initial
 Single Married Widowed Separated Divorced

Home Address _____
 Street City State Zip

Home Phone # _____ Business Phone # _____ Ext. _____ Cell Phone# _____ Email Address _____

Employed by: _____
 Business Name Address = Street City Zip

Who can we thank for referring you? _____

In case of emergency who should be notified? _____
 Name Relation to Patient Phone

DENTAL INSURANCE INFORMATION

Primary Insurance =

Insurance Co: _____
 Co. Name Address Group#

Insurance Subscriber: _____
 Name Relation to Patient Birthdate

_____ Social Security # (or subscriber number) Employer

Additional Insurance =

Insurance Co: _____
 Co. Name Address Group#

Insurance Subscriber: _____
 Name Relation to Patient Birthdate

_____ Social Security # (or subscriber number) Employer

HEALTH QUESTIONNAIRE

(This information is necessary for our records and your health. It is considered confidential)

Patient Name: _____

Date: _____

MEDICAL HISTORY

1. What is your estimation of your general health? Excellent Good Fair Poor
2. Are you now under the care of a physician If yes, for what condition? _____ Yes No
3. Have you ever been hospitalized or had a serious illness? If yes, explain _____ Yes No
4. Have you ever had surgery? Yes No
5. Have you ever had excessive bleeding requiring special treatment?..... Yes No
6. Are you on a special diet? If yes, what type? _____ Yes No
Have you ever taken Phen-Fen? Also known as Redux or Pondimin..... Yes No
7. Do you use alcoholic beverages? (more than 2 drinks a day)..... Yes No
8. Do you use tobacco now? Yes No
What Kind? Snuff Pipe Cigars Cigarettes
How much? _____
9. Are you an ex-smoker? Yes No

10. Are you ALLERGIC or SENSITIVE to any drugs or medications?

	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
Penicillin	<input type="checkbox"/>	<input type="checkbox"/>	Aspirin	<input type="checkbox"/>	<input type="checkbox"/>
Other Antibiotics	<input type="checkbox"/>	<input type="checkbox"/>	Codeine	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates/Sedatives	<input type="checkbox"/>	<input type="checkbox"/>	Other _____		

11. Have you ever had any of the following:

	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Family history of Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Heart Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Swelling of ankles	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Persistent cough	<input type="checkbox"/>	<input type="checkbox"/>
Mitral valve prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Sinus problems	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Condition	<input type="checkbox"/>	<input type="checkbox"/>
Congenital heart disease	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Artificial heart valve	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Blood clots	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Artificial Joints	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain/discomfort	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A, B or C	<input type="checkbox"/>	<input type="checkbox"/>
Tire easily, weakness	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid condition/goiter	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness/fainting	<input type="checkbox"/>	<input type="checkbox"/>	Venereal disease	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric Treatment	<input type="checkbox"/>	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	<input type="checkbox"/>
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Radiation therapy	<input type="checkbox"/>	<input type="checkbox"/>
	<u>Yes</u>	<u>No</u>			

- | | <u>Yes</u> | <u>No</u> |
|----------------------|--------------------------|--------------------------|
| Cancer - type: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Bruise easily | <input type="checkbox"/> | <input type="checkbox"/> |
| Bleeding tendency | <input type="checkbox"/> | <input type="checkbox"/> |
| Anemia | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood transfusions | <input type="checkbox"/> | <input type="checkbox"/> |
| HIV positive | <input type="checkbox"/> | <input type="checkbox"/> |
| A.I.D.S | <input type="checkbox"/> | <input type="checkbox"/> |
| Drug addiction | <input type="checkbox"/> | <input type="checkbox"/> |
| Osteoporosis | <input type="checkbox"/> | <input type="checkbox"/> |
| Other: _____ | | |

- Women:
- | | | |
|-------------------------------------|--------------------------|--------------------------|
| Are you pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you taking birth control pills? | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you taking hormones? | <input type="checkbox"/> | <input type="checkbox"/> |

12. MEDICATIONS::
Are you taking any of the following medications?

	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
Antibiotics/Sulfa drugs	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid medication	<input type="checkbox"/>	<input type="checkbox"/>
Blood thinners	<input type="checkbox"/>	<input type="checkbox"/>	Insulin/other diabetes drugs	<input type="checkbox"/>	<input type="checkbox"/>
Blood pressure medication	<input type="checkbox"/>	<input type="checkbox"/>	Cortisone/Steroids	<input type="checkbox"/>	<input type="checkbox"/>
			Nitroglycerin	<input type="checkbox"/>	<input type="checkbox"/>

- | | <u>Yes</u> | <u>No</u> |
|-----------------------------|--------------------------|--------------------------|
| Digitalis/other heart drugs | <input type="checkbox"/> | <input type="checkbox"/> |
| Aspirin | <input type="checkbox"/> | <input type="checkbox"/> |

If you are taking medication please list name and dose below:

Name	Dosage	Name	Dosage
1. _____	_____	4. _____	_____
2. _____	_____	5. _____	_____

3. _____ 6. _____

13. Is there any disease, condition, or problem not listed that you think we should know about, or is there any activity your doctor says you cannot do? If so explain: _____

Name of Family Physician: _____	Name of Family Dentist: _____
City: _____ Tel: _____	City: _____ Tel: _____
Name of Medical Specialist: (i.e., Cardiologist, Surgeon, OB-GYN)	Name of Dental Specialist: (i.e., Orthodontist, Endodontist, Oral Surgeon)
City: _____ Tel: _____	City: _____ Tel: _____

DENTAL HISTORY

	Yes	No
14. Have you come to this office for relief of pain?	<input type="checkbox"/>	<input type="checkbox"/>
15. Are you aware of any problems with your gums or teeth?	<input type="checkbox"/>	<input type="checkbox"/>
16. Have you ever had any unfavorable reaction from anesthetic (novocaine)?	<input type="checkbox"/>	<input type="checkbox"/>
If so explain: _____		
17. Does dental treatment make you nervous or apprehensive?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, please check: <input type="checkbox"/> Slight <input type="checkbox"/> Moderate <input type="checkbox"/> Extremely		
18. Have you had excessive bleeding problems associated with dental treatment?	<input type="checkbox"/>	<input type="checkbox"/>
19. Have you ever had a gum boil or abscess?.....	<input type="checkbox"/>	<input type="checkbox"/>
20. Are you missing any teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Why? <input type="checkbox"/> Cavities <input type="checkbox"/> Gum disease <input type="checkbox"/> Other		
21. Have you had periodontal treatment before?	<input type="checkbox"/>	<input type="checkbox"/>
22. How long since your last dental treatment? _____		
23. When was your last dental cleaning? _____		
24. How long since dental x-rays of your entire mouth? _____		
25. How often do you brush? _____		
Is your toothbrush: <input type="checkbox"/> soft <input type="checkbox"/> medium <input type="checkbox"/> hard Do you use: <input type="checkbox"/> Handbrush <input type="checkbox"/> Electric		
Do you use:	Yes	No
Dental Floss	<input type="checkbox"/>	<input type="checkbox"/>
Toothpicks	<input type="checkbox"/>	<input type="checkbox"/>
Interdental Stimulators	<input type="checkbox"/>	<input type="checkbox"/>
WaterPik	<input type="checkbox"/>	<input type="checkbox"/>
InterPlak brush	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		

Have you had any of the following?

	Yes	No		Yes	No
Bleeding, sore gums	<input type="checkbox"/>	<input type="checkbox"/>	Loose teeth	<input type="checkbox"/>	<input type="checkbox"/>
Unpleasant taste/Bad breath	<input type="checkbox"/>	<input type="checkbox"/>	Sensitive to hot	<input type="checkbox"/>	<input type="checkbox"/>
Burning tongue/lips	<input type="checkbox"/>	<input type="checkbox"/>	Sensitive to cold	<input type="checkbox"/>	<input type="checkbox"/>
Frequent blisters,lips/mouth	<input type="checkbox"/>	<input type="checkbox"/>	Sensitive to sweet	<input type="checkbox"/>	<input type="checkbox"/>
Swelling/bumps in mouth	<input type="checkbox"/>	<input type="checkbox"/>	Sensitive to biting/chewing	<input type="checkbox"/>	<input type="checkbox"/>
Ortho treatment (braces)	<input type="checkbox"/>	<input type="checkbox"/>	Food impaction	<input type="checkbox"/>	<input type="checkbox"/>
Biting cheeks/lips	<input type="checkbox"/>	<input type="checkbox"/>	Clenching/grinding	<input type="checkbox"/>	<input type="checkbox"/>
Clicking/popping jaw	<input type="checkbox"/>	<input type="checkbox"/>	Shifting of teeth	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty closing jaw	<input type="checkbox"/>	<input type="checkbox"/>	Change in bite	<input type="checkbox"/>	<input type="checkbox"/>

Are you happy with the way your smile looks? _____ If not, what would you change? _____

I understand that the information that I have given is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

 Patient Signature, (If minor, Parent or Guardian signature) _____
 Date

Insurance Assignment and Release

I, the undersigned, assign directly to Dr. Braden C. Seamons insurance benefits, if any, otherwise payable to me for services rendered to my dependant or myself. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize this office to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature

Relation to Patient

Date

Conditions of Treatment and Payment

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred to their care and financial responsibility on the part of each patient must be determined before treatment.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office can not render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1 1/2% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 90 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for dental care can only be extended for a period of six months from the date of the patient's examination.

I have read the above conditions of treatment and payment and agree to their content.

Signature of Patient, Parent, or Guardian

Relation to patient

Date