Solid City Smiles

Comfort, Excellence, and Experience in Periodontics and Dental Implants

Drs. Gregg R. Codelli & Sadja Gaud
Periodontists

Welcome to Our Practice!

Please fill out front and back (both pages) and sign as indicated on both back sides.

Patient_____ SSN _____

Spouse's Name_____ Spouse's SSN_____

Patient Date of Birth _____ Spouse's Date of Birth _____

Street Address _____

City/State/ZIP _____

Cell/Mobile_____ Home Ph. _____

Work Ph. _____ Spouse Cell/Mobile _____

email _____ Patient Employer _____

How may we contact you during the day? ☐ cell/mobile ☐ home ☐ work

Patient Diagnostic Information

Who referred you to us? ☐ Dr. _____ ☐ self

☐ Internet/online ☐ other patient _____ ☐ insurance plan

In your own words, why does your dentist or you feel you need to see us? _____

_____

_____

Based on what your dentist has told you and what you know about your mouth, please rate the condition of your mouth on a scale of 1 to 10 where 1 is severe disease and 10 is optimal health. (worst) 1 2 3 4 5 6 7 8 9 10 (best)

Are you in PAIN right now? ☐ YES ☐ NO If yes, does the pain keep you awake at night? ☐ YES ☐ NO

Physician's Name and Office Number _____

Name & Number of Person To Be Contacted in Case of Emergency, Other Than Spouse: _____

Name:_____ Phone # _____

When was the date of your LAST DENTAL CLEANING? _____

When was the date of your LAST FULL MOUTH X-RAYS (20 or more films)? _____

Have you had any type of PREVIOUS periodontal/gum therapy (including SCALING/DEEP CLEANING)? ☐ YES ☐ NO

If yes, when and where was periodontal treatment completed? _____

_____

Dental Insurance

PRIMARY DENTAL

Name of Insurance _____

Address _____

Phone _____

Group # _____

Member # _____

SECONDARY *Complete Spouse Section Only If There Is Secondary Insurance*

Name of Insurance _____

Spouse Employer _____

Phone _____

Group # _____

Member # _____

Medical Insurance

PRIMARY MEDICAL

Name of Insurance _____

Address _____

Phone _____

Group # _____

Member # _____

SECONDARY *Complete Spouse Section Only If There Is Secondary Insurance*

Name of Insurance _____

Spouse Employer _____

Phone _____

Group # _____

Member # _____

Statement and Consent to Financial Arrangements

1. Responsibility for payment for professional services provided in this office are due and payable at the time services are rendered unless prior financial arrangements have been made.
2. As a courtesy to patients, the business staff will assist in ascertaining insurance benefits (predetermination of benefits).
3. Responsibility for payment for professional services provided in this office are due and payable if for any reason insurance benefits are not made available.
4. It is the patient's (or guarantor's) responsibility to inform the office of any changes in insurance coverage.
5. A fee will be charged for filing any additional insurance other than primary.
6. A nominal fee will be assessed if 24-hour advance cancellation notice for appointments is not given.
7. A 1.5% monthly interest fee will be charged on balances over 30 days due (18% A.P.R.).
8. I authorize the release of all necessary information and I authorize payment of benefits directly to the Solid City Smiles.

Signature of Patient or Guarantor of Account: _____ Date: _____

For Your Information...

1. Dental insurance is not meant to be a "PAY-ALL;" it is meant to be an aid.
2. The amount your plan pays is determined by the contribution you and your employer make to your dental plan.
3. It has been the experience of many dentists that insurance companies tell their customers that "fees are above the usual and customary fees" rather than saying that "our benefits are too low." Remember you get back only what you and your employer put into your insurance coverage less the profits of the insurance company.
4. Each plan utilized in our office has different percentages, deductible, maximums, procedures covered, and varying fees that the plan will allow. We will do our very best to make as close a calculation as possible of what your insurance plan will cover. However, as we cannot estimate precisely, there may be variances for which the patient is individually responsible.
5. We make our recommendations for your well-being based on your dental needs and not on what your insurance may or may not cover.

Solid City Smiles Medical History (provide details if possible)

Are you in good health? ☐ YES ☐ NO

Has there been any change in your general health within the year? ☐ YES ☐ NO

Are you now under a physician's care? ☐ YES ☐ NO

Have you had any serious illness or operation? ☐ YES ☐ NO

Have you been hospitalized or had a serious illness within the past 5 years? ☐ YES ☐ NO

Have you had any history of tumors, malignancies, or treatment for cancer of any nature? ☐ YES ☐ NO

Do you ever have pain in your chest upon exertion? ☐ YES ☐ NO

Are you ever short of breath after mild exertion? ☐ YES ☐ NO

Do you require extra pillows when you sleep or do you get short of breath when you lie down? ☐ YES ☐ NO

Do your ankles swell? ☐ YES ☐ NO

Do you have a cardiac pacemaker? ☐ YES ☐ NO

Have you ever received a blood transfusion? ☐ YES ☐ NO

Have you had abnormal bleeding associated with previous surgery (any type), extraction or trauma? ☐ YES ☐ NO

What MEDICATION(S), if any, are you currently taking (e.g.,antibiotics, insulin, aspirin, anticoagulant, medication for high blood pressure, etc.)?

_____

_____

Have you ever taken any of the following medications: Fosamax (alendronate sodium), Boniva (ibandronate sodium), Actonel (risedronate sodium), Reclast (zoledronic acid), Zometa (zoledronic acid), Aredia (pamidronate disodium), Prolia (denosumab)? ☐ YES ☐ NO

If yes: Month/Year Started _____ Month/Year Stopped _____

ARE YOU ALLERGIC TO, OR HAVE YOU REACTED ADVERSELY TO (check or provide details of any not listed):

☐ Local anesthetic(s)	☐ Epinephrine	☐ Latex	☐ Iodine/Shellfish	
☐ Penicillin	☐ Amoxicillin	☐ Tetracycline	☐ Erythromycin	☐ Other antibiotics
☐ Aspirin	☐ Advil	☐ Aleve	☐ Other NSAIDS	
☐ Codeine	☐ Morphine	☐ Demerol	☐ Other narcotic analgesics	
☐ Versed	☐ Valium	☐ Scopolamine	☐ Barbiturates	☐ Other sedatives/sleeping pills

Have You Had or Do You...

Heart disease/heart attack/MI	☐ YES	☐ NO		Anemia	☐ YES	☐ NO	
Coronary bypass grafts	☐ YES	☐ NO		Hiatal hernia	☐ YES	☐ NO	
Hypertension/high blood pressure	☐ YES	☐ NO		Pollen/food allergies	☐ YES	☐ NO	
High cholesterol	☐ YES	☐ NO		Sinus trouble	☐ YES	☐ NO	
Congestive heart failure	☐ YES	☐ NO		Osteoarthritis	☐ YES	☐ NO	
Angina (chest pain)	☐ YES	☐ NO		Osteoporosis/osteopenia	☐ YES	☐ NO	
Rheumatic fever	☐ YES	☐ NO		Asthma	☐ YES	☐ NO	
Bruise easily	☐ YES	☐ NO		Hepatitis/jaundice	☐ YES	☐ NO	
Artificial heart valve	☐ YES	☐ NO		Liver disease	☐ YES	☐ NO	
Congenital heart condition	☐ YES	☐ NO		Tuberculosis	☐ YES	☐ NO	
Mitral valve prolapse or heart murmur	☐ YES	☐ NO		Substance addiction or alcoholism	☐ YES	☐ NO	
Artificial joint in place	☐ YES	☐ NO		Hemodialysis	☐ YES	☐ NO	
Stroke (CVA) or TIA's	☐ YES	☐ NO		Hemophilia	☐ YES	☐ NO	
Emphysema/COPD	☐ YES	☐ NO		Sleep apnea	☐ YES	☐ NO	
Diabetes (Type 1, insulin-dependent)	☐ YES	☐ NO		HIV/AIDS	☐ YES	☐ NO	
Diabetes (Type 2, no insulin)	☐ YES	☐ NO		Panic anxiety	☐ YES	☐ NO	
Kidney trouble	☐ YES	☐ NO		Persistent cough or cold	☐ YES	☐ NO	
Thyroid disease	☐ YES	☐ NO		Radiation treatment	☐ YES	☐ NO	
Seizure disorder	☐ YES	☐ NO		Rheumatoid arthritis	☐ YES	☐ NO	
Bleeding disorder	☐ YES	☐ NO		Depression/anxiety	☐ YES	☐ NO	

Women Only

Are you pregnant (yes if not sure)? ☐ YES ☐ NO
Do you anticipate becoming pregnant? ☐ YES ☐ NO
Are you nursing? ☐ YES ☐ NO
Are you taking birth control pills? ☐ YES ☐ NO

Solid City Smiles Dental History

How many times per year do you get your teeth CLEANED? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ occasionally ☐ never
How many times a day do you BRUSH your teeth? ☐ 1 ☐ 2 ☐ 3 ☐ occasionally ☐ after meals
Do you use an ELECTRIC toothbrush (if so, what brand)? ☐ YES _____ ☐ NO
Do you use a WaterPik or WaterFlosser (if so, what brand)? ☐ YES _____ ☐ NO
How many times a day do you FLOSS? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ occasionally ☐ after meals
How many times a day do you use TOOTHPICKS? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ occasionally ☐ after meals
How many times a day do you use an INTERDENTAL or PROXABRUSH? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ occasionally ☐ after meals
How many times a day do you use SUPERFLOSS? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ occasionally ☐ after meals
How many times a day do you use RUBBER TIPS or STIMUDENTS? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ occasionally ☐ after meals
Do you use TOBACCO in any form (if so, what type and how often)? ☐ YES _____ ☐ NO
If applicable, how long have you worn dentures? _____

Please check YES or NO to the following providing details if possible

Have you ever been given professional instructions on how to clean your teeth and gums? ☐ YES ☐ NO
Have you noticed any loosening of the teeth? ☐ YES ☐ NO
Has anyone in your family lost teeth because of periodontal disease or pyorrhea? ☐ YES ☐ NO
Are any of your teeth sensitive to hot or cold? If so, where? ☐ YES ☐ NO
Do your gums bleed? If so, where? ☐ YES ☐ NO
Are your gums sore, tender, spongy or red? If so, where? ☐ YES ☐ NO
Do any of your teeth hurt to bite on? If so, where? ☐ YES ☐ NO
Do you have a problem with food packing between your teeth? If so, where? ☐ YES ☐ NO
Do you often experience bad taste or odor in the mouth? ☐ YES ☐ NO
Do you grind or clench your teeth? ☐ YES ☐ NO
Have you had braces (orthodontics)? ☐ YES ☐ NO
Do your jaw joints pop or click? ☐ YES ☐ NO
Do you have difficulty speaking? ☐ YES ☐ NO
Do you have difficulty swallowing? ☐ YES ☐ NO
Is there pain in your jaw joints? ☐ YES ☐ NO
Are you very nervous in the dental office? ☐ YES ☐ NO
Have you ever fainted in the dental office? ☐ YES ☐ NO
Do you have difficulty chewing food? ☐ YES ☐ NO
Do you gag easily? ☐ YES ☐ NO
Do you like the appearance of your teeth? ☐ YES ☐ NO
Do you avoid smiling because of your teeth or mouth? ☐ YES ☐ NO
Do you avoid going out in public because of your teeth or mouth? ☐ YES ☐ NO
Do you avoid certain types of foods due to dental disease or mouth comfort? ☐ YES ☐ NO
Do you think your teeth are affecting your health in any way? ☐ YES ☐ NO
Have you ever had a negative or traumatic experience in the dental office? ☐ YES ☐ NO
Have you ever had an injury to your face or jaws? ☐ YES ☐ NO
Are you pleased with your partial or denture (removable or bridge)? ☐ YES ☐ NO
Please provide any other comments you feel may be appropriate to your needs. _____

_____

Responsibility and Consent Statement

If I have any change in health, I will inform the doctor at the beginning of my next visit.

Signature of Patient: _____ Date: _____

Signature of Doctor: _____ Date: _____