PERIODONTICS & DENTAL IMPLANTS

Douglas L. Reigh, D.M.D.

27 Village Center Drive, Reading, PA 19607

(610) 777-7002

www.drreigh.com

Today's Date: _____

PATIENT INFORMATION

Patient's Name: _____
(First Name) (M.I.) (Last Name)

I preferred to be addressed as / my nickname is: _____

SS #:_____ **DOB:** _____ **Sex:** ☐ M ☐ F
(Full SS# required for all patient's with insurance)

Address: _____
(Street Address) (City/State) (Zip Code)

Home Phone: _____ **Cell Phone:** _____

Email: _____

Occupation_____ **Employer**_____

Work Phone_____ **Preferred Contact Method?** ☐ Home Phone ☐ Cell Phone ☐ Work Phone

Responsible Party on Account: _____ **Relationship to Patient:** _____

Responsible Party's phone #: _____

Marital Status: ☐ M ☐ S ☐ D ☐ W ☐ Full time student--School? _____

Messages regarding your care and appointments may be left at the following sources (Check all that apply):

☐ Home Phone ☐ Cell Phone ☐ Work Phone

EMERGENCY CONTACT INFORMATION:

In case of emergency, whom should we notify? _____

Relationship to Patient: _____ Phone: _____

REFERRING DENTIST/PRIMARY CARE PHYSICIAN INFORMATION:

Referring/General Dentist: _____

My major dental problem/Reason for seeking periodontal treatment_____

_____

Who is your Primary Care Physician? _____

Do you see any other specialists? Please list Dr. and specialty_____

_____

_____

INSURANCE COVERAGE: (we will need to make a copy of your cards –ALL information MUST be completed below in order for our office to bill the insurance company.)

Primary Insurance Company Name: _____

Pri. Ins. Company Address: _____

Pri. Ins. Company Phone #: _____

Subscriber to Primary Insurance _____ Subscriber DOB: _____

ID# or Subscriber SS# _____ Patient's relationship to Subscriber _____

Secondary Insurance Company Name: _____

Sec. Ins. Company Address:

_____

Sec Ins. Company Phone #: _____

Subscriber to Secondary Insurance _____ Subscriber DOB: _____

ID# or Subscriber SS#: _____ Patient's relationship to Subscriber _____

Note: We do NOT participate with insurances, but we will submit claims to your insurance. The patient will be responsible for our fees at the time of service. The patient will be reimbursed by the insurance company directly. We do NOT bill Medicare/Medicaid. In the event your insurance sends the reimbursement check to our office, we will issue the responsible party on account a refund. Please see more on our financial policy form.

PHARMACY INFORMATION

Pharmacy Name: _____ Phone #: _____

Address: _____

I hereby authorize the practicing dentist at this facility to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. To the best of my knowledge, all of the preceding answers are true and correct. If I have any changes, I will inform Dr. Douglas L. Reigh at my next appointment.

_____

Signature of patient **Date**

_____

Signature of parent if patient is a dependent child **Date**

MEDICAL HISTORY

PATIENT NAME_____ DATE OF BIRTH_____

Are you under a physician's care now? ○ Yes ○ No If yes, explain_____
Have you ever been hospitalized/had a major operation? ○ Yes ○ No If yes, explain_____
Have you ever had a serious head or neck injury? ○ Yes ○ No If yes, explain_____
Do you take, or have you taken, Phen-Fen or Redux? ○ Yes ○ No If yes, explain_____

Have you ever taken Fosamax, Boniva, Actonel, or any other medication containing bisphosphonates? ○ Yes ○ No If yes, explain_____
Are you on a special diet? ○ Yes ○ No If yes, explain_____
Do you use tobacco? ○ Yes ○ No If yes, explain_____
Do you use controlled substances? ○ Yes ○ No If yes, explain_____
Do you pre-medicate for your dental visits? ○ Yes ○ No If yes, explain_____
Are you on and Blood Thinners or Anticoagulants? ○ Yes ○ No If yes, explain_____
Do you take Aspirin daily? ○Yes ○No If yes, explain_____
Do you take any medications for erectile dysfunction? ○ Yes ○ No If yes, explain_____
Do you take Fish oil or Garlic supplements? ○ Yes ○No If yes, explain_____

Women, Are you:

Pregnant/Trying to get pregnant? ○ Yes ○ No Taking Oral Contraceptives? ○ Yes ○ No Nursing? ○ Yes ○ No

Are you allergic to any of the following?

○ Aspirin ○ Penicillin ○ Codeine ○ Acrylic ○ Metal ○ Latex ○ Local Dental Anesthetics ○ Sulfa Drugs ○ Iodine/Shellfish
○ Other, please explain_____

Do you have, or had, any of the following?

AIDS/HIV Positive	○ Yes ○ No	Cortisone Medicine	○ Yes ○ No	Hemophilia	○ Yes ○ No	Radiation Treatments	○ Yes ○ No
Alzheimer's Disease	○ Yes ○ No	Diabetes	○ Yes ○ No	Hepatitis A	○ Yes ○ No	Recent Weight Loss	○ Yes ○ No
Anaphylaxis	○ Yes ○ No	Alcohol/Drug Addiction	○ Yes ○ No	Hepatitis B or C	○ Yes ○ No	Renal Dialysis	○ Yes ○ No
Anemia	○ Yes ○ No	Easily Winded	○ Yes ○ No	Herpes	○ Yes ○ No	Rheumatism	○ Yes ○ No
Angina	○ Yes ○ No	Emphysema	○ Yes ○ No	High Blood Pressure	○ Yes ○ No	Scarlet Fever	○ Yes ○ No
Arthritis/Gout	○ Yes ○ No	Epilepsy/Seizures	○ Yes ○ No	High Cholesterol	○ Yes ○ No	Shingles	○ Yes ○ No
Artificial Heart Valve	○ Yes ○ No	Excessive Bleeding	○ Yes ○ No	Hives or Rash	○ Yes ○ No	Sickle Cell Disease	○ Yes ○ No
Artificial Joint	○ Yes ○ No	Excessive Thirst	○ Yes ○ No	Hypoglycemia	○ Yes ○ N	Sinus Trouble	○ Yes ○ No
Asthma	○ Yes ○ No	Fainting Spells/Dizziness	○ Yes ○ No	Irregular Heartbeat	○ Yes ○ No	Spina Bifida	○ Yes ○ No
Blood Disease	○ Yes ○ No	Frequent Cough	○ Yes ○ No	Kidney Problems	○ Yes ○ No	Stomach/Intestinal Disease	○ Yes ○ No
Blood Transfusion	○ Yes ○ No	Frequent Diarrhea	○ Yes ○ No	Leukemia	○ Yes ○ No	Stroke	○ Yes ○ No
Breathing Problem	○ Yes ○ No	Frequent Headaches	○ Yes ○ No	Liver Disease	○ Yes ○ No	Thyroid Disease	○ Yes ○ No
Bruise Easily	○ Yes ○No	Genital Herpes	○ Yes ○ No	Low Blood Pressure	○ Yes ○ No	Tonsillitis	○ Yes ○ No
Cancer	○ Yes ○ No	Glaucoma	○ Yes ○ No	Lung Disease	○ Yes ○ No	Tuberculosis	○ Yes ○ No
Chemotherapy	○ Yes ○ No	Hearing Problems	○ Yes ○ No	Mitral Valve Prolapse	○ Yes ○ No	Tumors/Growths	○ Yes ○ No
Chest Pains	○ Yes ○ No	Heart Attack/Failure	○ Yes ○ No	Osteoporosis	○ Yes ○ No	Ulcers	○ Yes ○ No
Cold Sores/Fever Blisters	○ Yes ○ No	Heart Murmur	○ Yes ○ No	Pain in Jaw Joints	○ Yes ○ No	Venereal Disease	○ Yes ○ No
Congenital Heart Disorder	○ Yes ○ No	Heart Pacemaker	○ Yes ○ No	Parathyroid Disease	○ Yes ○ No	Vision Problems	○ Yes ○ No
Convulsions	○ Yes ○ No	Heart Trouble/Disease	○ Yes ○ No	Psychiatric Care	○ Yes ○ No	Yellow Jaundice	○ Yes ○ No

Have you ever had any serious illness not listed above? Please explain _____

Please list all medications you are taking below:

_____
_____
_____
_____
_____
_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____ _____
Signature of Patient, Parent, or Guardian Date