Cedar Rapids Periodontics & Dental Implants

Joseph Ballatore, DMD
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319.365.6150
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info@cedarrapidsperio.com

Patient Name ______________________________ DOB ____________________________

Email Address ______________________________ Cell _____________ Home ___________

Address ____

Emergency Contact: Name_________________ Phone ___________ Relationship _________

Are you under a physician's care now? O Yes O No _____________________________

Primary health physician's name _________________________ Pregnant? O Yes O No

Have you ever been hospitalized or had a major operation? O Yes O No _____________

____

Are you taking any current medications? O Yes O No If yes please list: _______________

____

Do you have any allergies to the following? Please circle: Penicillin Latex Sulfa
Other allergies:____

Alcohol Use: O None O Monthly O Weekly O Daily

Smoking Use: O None O Less than 10 per day O 1 Pack Per Day

Tobacco Use: O Yes O No Type: ___________ Frequency: __________________

Do you have, or have had any of the following? Please circle yes or no, explain if necessary.

Condition		
High blood pressure	Yes	No
Heart attack: Date ________	Yes	No
Pacemaker: Date _________	Yes	No
Congestive heart failure	Yes	No
Heart surgery: Date ________	Yes	No
Stroke: Date _________	Yes	No
Epilepsy/ Seizure disorder	Yes	No
Excessive bleeding	Yes	No
Blood disorders: hemophilia/ anemia/ other __________	Yes	No
Hepatitis: Type _________	Yes	No
HIV or AIDS	Yes	No
Auto-immune disease: Type ___________	Yes	No
Thyroid disease	Yes	No
Liver problems	Yes	No
Kidney disease	Yes	No
GI disorders	Yes	No
Diabetes: Type __________ A1C __________	Yes	No

Condition		
Lung disease/ COPD/ Emphysema	Yes	No
Tuberculosis or positive skin test	Yes	No
Asthma: When does this effect you? ___________________	Yes	No
Skin diseases/ problems: Type ____________	Yes	No
Cancer: Type and Date __________________	Yes	No
Chemotherapy: Date ___________________	Yes	No
Radiation therapy: Date and targeted location ___________________________	Yes	No
Arthritis: Type __________________________	Yes	No
Prosthetic joint replacements: Knee, Hip, Shoulder, Elbow, Other Date ___________	Yes	No
Depression or Anxiety	Yes	No
Alcohol or drug abuse: Current, treated, Date treated _______________	Yes	No
Sinus problems seasonal	Yes	No
Other conditions: _______________________ ______________________________________	Yes	No

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When was your last dental appointment: Date _______________ What was done? _____________________________
Do you have regular cleanings with your dentist? Yes No Frequency____________________________________
Are you having any pain or discomfort in your mouth currently? Yes No ____________________________________
Have you ever had periodontal surgery in the past? Yes No ____
Have you been treated for periodontal (gum) disease in the past? Yes No __________________________________

Do your gums bleed with brushing? Yes No ____
Are your teeth sensitive to any of the following? Cold Hot Sweets Chewing food _________________________
Do your teeth move, or are they shifting from their original places? Yes No _________________________________
Do you clench or grind your teeth? Yes No When? ____
How often do you brush your teeth per day? _________________ How often do you floss? _____________________
Are you apprehensive about being at the dental office or dental treatment? Yes No __________________________
____

General dentist's name _________________________ Did this office refer you? Yes No Other ___________________
Reason for todays visit ____
Is there anything else you want checked today? ____

Patient's Primary Dental Insurance

Policy holder's name ______________________________
Insurance company name __________________________
Subscriber ID# or SSN _____________________________
Group # ____
Are you a dependent on a spouse or parents plan for the primary coverage? (Spouse Parent)
Policy holder's DOB _______________________________
Policy holder's phone ______________________________
Policy holder's employer ___________________________
Address - Same as patient? Yes No _________________
____

Patient's Secondary Dental Insurance

Policy holder's name ______________________________
Insurance company name __________________________
Subscriber ID# or SSN _____________________________
Group # ____
Are you a dependent on a spouse or parents plan for the secondary coverage? (Spouse Parent)
Policy holder's DOB _______________________________
Policy holder's phone ______________________________
Policy holder's employer ___________________________
Address – Same as patient? Yes No _________________
____

By signing this form, I have either received or reviewed a copy of the Truth-in-Lending Statement and agree to the terms of my financial responsibilities. Copies of the Truth-in-Lending Statement can be found in our office or on our website.

Please remember to arrive 10 minutes early to your appointment for check in.
Things to bring with you – Paperwork filled out prior to arrival, medications list if you have one, insurance cards

We welcome you to our office and look forward to your visit!

Sign here X____ Today's Date_________________________________