Roman S. Melnyk, DDS, MS
Establishing a Healthy Foundation

Periodontics and Implants

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Welcome to our office. Please complete the following confidential questionnaire.

PERSONAL INFORMATION

ADULT PATIENTS

Date:_____
Name:_____ Jr. Sr. III Age:_____ Birthdate:_____ Sex:_____
Social Security No.:_____ By what name would you like us to call you:_____
Mailing Address:_____ How long lived there?_____ Phone:_____
STREET
_____ Home Address if different _____
CITY STATE ZIP
Employer:_____ Occupation:_____
Business Address:_____ Phone:_____
Marital Status: Married_____ Single_____ Widowed_____ Divorced _____
Spouse's Name:_____
Spouse's Employment:_____ Address:_____ Phone:_____

CHILD AND ADOLESCENT PATIENTS

Date:_____
Child's Name:_____ Jr. III Age:_____ Birthdate:_____ Sex:_____
Mailing Address:_____ Phone:_____
Mother's Name:_____ Address if Different _____ Phone:_____
Father's Name:_____ Address if different _____ Phone:_____

ACCOUNT INFORMATION

☐ Check here if patient is responsible for account. If so, go to (b.)

a. Person Responsible for Account Payment
Name:_____ Relationship to Patient:_____ Soc. Sec. No.:_____
Mailing Address:_____ Phone:_____
STREET CITY STATE & ZIP
Employer:_____ Occupation:_____
Business Address:_____ Phone:_____
b. Preferred Method of Payment: Cash_____ Check_____ MasterCard/Visa_____
Primary Dental Insurance Carrier Co.:_____
Employee:_____ Group #_____ Policy # _____
Secondary Dental Insurance Carrier Co.: _____
Employee:_____ Group #_____ Policy #_____

GETTING TO KNOW YOU

Person to Contact for Emergency:_____ Jr. Sr. III Relationship:_____
Address:_____ Phone:_____
Closest Relative Not Living with You:_____ Jr. Sr. III Relationship:_____
Address:_____ Phone:_____
Have we treated a member of your family or friends at our office?_____ If so, who?_____
Is there anything special you would like us to know about you?_____
_____
Any Special hobbies or interests you like to talk about?_____
_____

PLEASE CONTINUE ON THE INSIDE WITH THE MEDICAL AND DENTAL HISTORIES

DENTAL HEALTH HISTORY

Are you now in discomfort requiring immediate attention? YES NO (If YES, Please Explain)

_____

_____

_____

Your Present Dentist:_____How long?_____Date of last visit_____

Former Dentist:_____How long?_____

Reason you were referred or Nature of your problem:_____

_____

_____

_____

Do you have, or have you ever had, any of the following? Please Circle:

Orthodontic Treatment	Jaw Fractures	Sore Jaws or Jaw Pain
Gum Treatment	Tooth Fractures	Jaw Popping or Locking
Oral Surgery	Partial Dentures	Bite Grinding or Bruxism
Bite Treatment	Dentures	Chronic Neck or Ear Pain
Root Canal Treatment	Crowns and/or Bridges	Dental Implants
Sensitive Teeth	Mouth Swelling	Burning of the Mouth

Please answer the following about your dental health:

1. My mouth is:
   A. very comfortable.
   B. moderately comfortable.
   C. uncomfortable.

2. I:
   A. think the appearance of my mouth is excellent.
   B. am satisfied with the appearance of my mouth.
   C. am dissatisfied with the appearance of my mouth.

3. I:
   A. will do anything to keep my natural teeth.
   B. want to keep my teeth, but have a certain budget of time and money that I am willing to spend on them.
   C. don't care whether I keep my teeth or not.

4. I:
   A. have set goals for my oral health with my referring dentist.
   B. want to set goals concerning my dental health.
   C. never set goals concerning my dental health.

5. I:
   A. have always done the best that was recommended for me.
   B. have not done what dentists have recommended for me.
   C. rarely go, and don't care much about having dental work completed.

6. I:
   A. have put dentistry for myself and family high on the priority list.
   B. have put dentistry for myself and family low on the priority list.
   C. do not have dentistry on a priority list at all.

7. I think my present state of dental health is:
   A. excellent.
   B. good.
   C. fair.
   D. poor.

8. I aspire to a mouth with:
   A. excellent health.
   B. good health.
   C. poor health.

Are you apprehensive about dental treatment?

_____

_____

_____

These are things that are important to me about my dental health:

_____

_____

_____

What are some questions about dentistry and oral health that you have never had adequately answered?

_____

_____

_____

MEDICAL HEALTH HISTORY

How would you describe your general health? Excellent Good Fair Poor

Are you under the care of a physician? YES NO (if YES, Please Explain)

_____

_____

_____

Physician's Name_____ Address_____ Phone_____

Family Physician's Name_____ Address_____ Phone_____

Do you have, or have you ever had, any of the following? Please Circle

Artificial Heart Valve	Heart Failure	Jaundice	Diabetes
Pace Maker	Synthetic Vein or Graft	Hepatitis (A B C)	Sinus Trouble
Heart Disease/Attack	Bleeding Problem	AIDS/HIV Infection	Asthma
High Blood Pressure	Blood Transfusions	Venereal Disease	Lung Disease
Low Blood Pressure	Blood Disorders, Anemia	Tumors or Growths	Chemotherapy
Heart Murmur	Rheumatic Fever	Radiation Therapy	Thyroid Disease
Mitral Valve Prolapse	Tuberculosis	Psychiatric Therapy	Glaucoma
A Stroke	Stomach or Intestinal Ulcers	Arthritis	Emphysema
Epilepsy	Skin Diseases	Liver or Kidney Disease	Shortness of Breath
Cortisone Treatment	Organ Transplant	Artificial Joints	Acne Treatments
Chemical Dependency	Cancer		

Do you have any disease, condition or problem not listed above? YES NO (If YES, Please Explain)

_____

_____

_____

Have you ever been instructed to pre-medicate with antibiotics for a dental appointment? YES NO (If YES, Explain)

_____

Have you been hospitalized and/or had surgery within the last five years? YES NO (If YES, Please Explain)

_____

_____

_____

Are you on any blood thinners or daily aspirin? YES NO (If YES, Please Explain)

_____

Are you taking any medication, pills, or drugs? YES NO (If YES, Please Explain)

_____

_____

_____

Are you allergic or sensitive to any of the following medications? Please Circle:

Penicillins	Aspirin	Lidocaine	Novocaine
Erythromycins	Tylenol	Xylocaine	Valium
Tetracyclines	Codeine	Carbocaine	Latex

List other medications you are allergic or sensitive to:_____

_____

_____

Do you Smoke? YES NO How Long?_____ Number of packs per day_____

WOMEN: Are you pregnant? YES NO Delivery Date?_____ Are you Nursing? YES NO When do you expect to stop nursing?_____ Taking Birth Control Pills? YES NO

Are you taking Hormone Replacement Medications? YES NO

Remarks_____

_____

_____

_____

A policy is a written statement which determines actions or activities of an organization. We have some important policies in our practice that we feel are important to share with you, our patient.

We have put them in writing because we live by them and require that all our patients live by them as well. We realize that the institution of these policies may be different from what you may be accustomed to in the past, however, we believe they are very necessary. We ask you to read this page thoroughly and then sign at the bottom so that you understand these policies and agree to comply with them.

COMMITMENT TO TREATMENT POLICY

We believe that treatment started should be completed. Periodontal disease is an infection caused by the common germs or bacteria normally found in one's mouth. Its successful treatment depends on the timely and thorough removal of these organisms from under the gumline and the prevention of further infection on a daily basis. In most cases, it takes several appointments to bring the disease under control, therefore, we strongly believe that all treatment begun must be completed to be of value to you, the patient. Incomplete treatment usually leads to disappointing results, complications and further disease progression which could lead to tooth loss.

COMMITMENT TO APPOINTMENT POLICY

All patients are treated on an appointment basis only. We do not "double-book" our patients. Your appointment time is reserved exclusively for you. An appointment in our office is a bond of trust and mutual respect that we will be here to serve you and that you will be present for appointments. Frequent cancellations or short notice changes (less than 24 hours notice) will not be tolerated. Our office policy is firm in this regard. In addition, every attempt is made to see patients on time and we ask that you be prompt for all scheduled appointments. We are careful to schedule our appointments appropriately, and if we keep you waiting too long, please let us know.

EMERGENCY APPOINTMENT POLICY

It is our policy to see all emergencies the day the patient calls our office or is referred by his or her dentist. We make every attempt to see that patient at a time when minimal disruption to our schedule will result. This is not always possible and we may, therefore, be thrown "off-schedule." We apologize to our regularly scheduled patients for this inconvenience, however, we feel that every patient in pain should receive prompt treatment to relieve that pain when possible.

FINANCIAL POLICY

No business or practice can fulfill its mission to its patients when a bond of trust is violated by failure to pay for services.

NEW PATIENTS — The new patient process is a two-appointment process which includes appointments for your Examination, Diagnosis and Treatment Planning Consultation, as well as for the taking of or duplication of dental x-rays. A payment covering these two appointments is required at your first appointment. In addition to cash and checks, we accept MasterCard, Visa, and Discover.

TREATMENT FEES — During your Diagnosis and Treatment Planning Consultation (2nd appointment), treatment fees will be presented and payment options will be discussed.

DENTAL INSURANCE — If you have any dental insurance coverage, we ask that you bring a signed insurance form with your portion of the form completed for a preauthorization, if your insurance company requires one. We do not, however, accept assignment nor payment from insurance companies, nor do we participate in any dental plans. You are responsible for the payment of any services received in our office.

I consent to examination as necessary or desirable, and to the care of the registered patient, for the diagnosis of dental/periodontal disease, or treatment of the dental/periodontal emergency. The procedure may include x-rays, intraoral exams, and photographs. In the case of a dental emergency, I consent to treatment as deemed necessary by the doctor, understanding that the procedures will be explained in advance. I have read and completed the questionnaire to the best of my knowledge and agree to the above policies.

PATIENT, PARENT OR LEGAL GUARDIAN	DATE	PERIODONTIST	DATE