GREAT PLAINS
PERIODONTICS & IMPLANT DENTISTRY

Welcome to our Practice

PATIENT'S LEGAL NAME:_____ PREFERRED NAME:_____
Last Middle First

BIRTH DATE:_____ GENDER:_____ FAMILY STATUS: ___married___single___child___other

SS#_____ PHONE#_____ _____ _____
Home Mobile Work

EMAIL ADDRESS:_____

ADDRESS:_____
Street or Mailing Address City State Zip

EMPLOYER:_____ OCCUPATION:_____

EMERGENCY CONTACT (Name, Relationship & Phone Number):_____

RESPONSIBLE PARTY INFORMATION:
Please enter information for the person/guardian financially responsible for the account

NAME:_____ RELATION TO PATIENT:_____
Last Middle First

BIRTH DATE:_____ SS#_____

PHONE#_____ _____ _____
Home Mobile Work

EMAIL ADDRESS:_____

ADDRESS:_____
Street or Mailing Address City State Zip

Robert J Moeller, DDS, MS, 1011 E Prescott Road, Salina, KS 67401
Phone: 785.404.1712 Fax: 785.404.1778
Email: reception@salinaperio.com Website: www.salinaperio.com

Great Plains Periodontics

www.salinaperio.com reception@salinaperio.com
Dr. Robert Moeller | 1011 E. Prescott • Salina, KS 67401 (785)404-1712

Medical History

Patient Name: _____ * _____ * ____ _____
Last First MI Preferred Name

Although dental personnel treat the area in and around your mouth, your mouth is part of your entire body. Health conditions or problems that you may have or had, or medications that you may be taking, could have important interrelationship with the treatment you will receive. Thank you for answering the following questions.

Indicate which of the following conditions you have or have had. By checking the box it will indicate a "YES" response, leaving blank will indicate a "NO" response.

Allergies

☐ Acrylics ☐ Anaphylaxis ☐ Latex ☐ Local Anesthetics ☐ Penicillin ☐ Metal ☐ Seasonal
☐ Sulfa ☐ Other

List other known allergies:

_____

_____

Cardiovascular

☐ Artificial Heart Valve ☐ Coronary Artery Disease ☐ Chest Pain or Angina ☐ Congestive Heart Failure ☐ Heart Attack
☐ Heart Murmur ☐ High Blood Pressure ☐ High Cholesterol ☐ Irregular Heart Beat/AFib ☐ Low Blood Pressure
☐ Mitral Valve Prolapse ☐ Pacemaker ☐ Tachycardia

Endocrine

☐ Diabetes ☐ Gout ☐ Hormonal Change ☐ Thyroid problems

If yes to Diabetes,
What was your last A1C? _____

Eyes, Ears, Nose and Throat

☐ Change in Hearing ☐ Change in Vision ☐ Dysphagia ☐ Ear Pain ☐ Glaucoma ☐ Hay Fever ☐ Nasal Obstruction
☐ Nose Bleeding ☐ Sinus Problems ☐ Tonsillectomy ☐ Tinnitus ☐ Do you snore?

Gastrointestinal

☐ Acid Reflex ☐ GERD ☐ Soft or Special Diet ☐ Ulcers

General

☐ Cancer ☐ Cold/Canker Sores ☐ Fatigue/Tiredness ☐ General Weakness ☐ Headaches
☐ HIV/AIDS ☐ Joint Replacement ☐ Liver problems ☐ Kidney Disease ☐ Recent Trauma or injury
☐ Rheumatic Fever ☐ Radiation Treatment ☐ Weight Change

Do you require premed antibiotics before dental procedures? ◯ Yes ◯ No

FEMALES ONLY:

☐ Taking Oral Contraceptives ☐ Pregnant or Nursing

Oral

- [ ] Bleeding problems
- [ ] Dry mouth
- [ ] Jaw problems (TMJ)
- [ ] Facial Pain
- [ ] Clenching/clicking/grinding
- [ ] Difficulty swallowing/chewing
- [ ] Orthodontics/Invisalign
- [ ] Periodontal Disease
- [ ] Tooth pain
- [ ] Wisdom teeth extraction
- [ ] Grind your teeth

Do you wear removable teeth? ◯ Yes ◯ No

Musculoskeletal

- [ ] Back pain
- [ ] Fibromyalgia
- [ ] Joint pain
- [ ] Rheumatoid arthritis
- [ ] Arthritis
- [ ] Osteoporosis

Are you taking any medication for RA or Osteoporosis? ◯ Yes ◯ No

Neurological

- [ ] Alzheimer's Disease
- [ ] Dizziness
- [ ] Fainting
- [ ] Memory Loss
- [ ] Multiple Sclerosis (MS)
- [ ] Muscle Weakness
- [ ] Seizures
- [ ] Stroke
- [ ] Tingling/Numbness
- [ ] Trigeminal Neuralgia
- [ ] Tremor

Are you taking any medications for bleeding problems or Stroke? ◯ Yes ◯ No

Psychiatric

- [ ] ADD/ADHD
- [ ] Anxiety
- [ ] Chemical Dependency
- [ ] Depression
- [ ] Eating disorders
- [ ] Excessive Stress
- [ ] Memory problems

Respiratory

- [ ] Asthma
- [ ] Bronchitis
- [ ] Breathing problems
- [ ] Chest Pressure
- [ ] Congestion
- [ ] Dyspnea (shortness of breath)
- [ ] Emphysema
- [ ] Orthopnea
- [ ] Pneumonia
- [ ] Pulmonary Embolism
- [ ] Tuberculosis

Sleep

- [ ] Daytime Sleepiness
- [ ] Morning headaches
- [ ] Obstructive Sleep Apnea

Do you use a CPAP ◯ Yes ◯ No

How often? _____

Social History

- [ ] Smoke Cigarettes
- [ ] Use Smokeless tobacco
- [ ] Consume alcoholics beverages
- [ ] Use recreational drugs

If checked, How many packs a day? _____

If checked, How many drinks per day/week/month? _____

Who is your general dentist? How often do you have your teeth cleaned?

_____

_____

List all medications (prescription and non-prescription):
Please include Medication, Dosage/Freq, Prescriber and Reason

List any surgeries or hospitalizations you have had:
Please include Year, Surgery, Surgeon and Reason

List and detail any medical condition or history not listed above:

Primary Physician's Name and phone #:

Are you under the care of other physicians? Yes/No
If so, please list physicians name, phone # and reason:

PREFERRED PHARMACY
Name, Phone Number and Location:

Response Date: _____

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Financial Agreement - HIPAA Privacy Authorization

Thank you for choosing Great Plains Periodontics and Implant Dentistry, PA (GPP) for your dental care. We appreciate that you have entrusted us with your care, and we are committed to providing you with the best patient care possible.

Insurance benefits and coverage options have become increasingly complex. We have developed this financial policy to help you better understand your responsibilities as a patient. We will do our best to assist you with understanding your costs and in answering questions related to submitting your insurance claim for reimbursement.

Insurance: We are considered an out-of-network provider for ALL insurance companies. Each patient plan has different benefits and financial obligations. Not all Insurance policies cover all services. You are responsible for the full payment of services rendered regardless of insurance coverage. You authorize GPP to release all information necessary to secure the payment of benefits. As a courtesy to our patients, we will submit claims to most insurance carriers for you.

Patient Balance, Payment Arrangements & Cancellation Policy: Full payment is due at the time of your scheduled procedure unless there are pre-arranged payment plans made and agreed upon. Some appointments will require a down payment on date of scheduling. You will be responsible for 100% of your appointment fee if you miss or cancel multiple appointments without 24 hours notice. This will not be covered by your insurance company and is non-refundable or transferable to a future appointment. A 1.5% per month (18% annually) service charge will be applied to any balance over 30 days. You agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

We accept cash, check, Visa, Mastercard, Discover, American Express and Care Credit. A $35.00 fee is assessed to any returned check.

Notice of Privacy Practices:
Patient privacy is important to our practice. We are required by law to maintain the privacy of Protected Health Information (PHI) and to provide individuals with notice of our legal duties and privacy practices with respect to PHI. You allow release of pertinent medical records to your insurance company (if applicable) and your other medical providers.

Your electronic signature will serve as your consent for this form and for the HIPAA Privacy Authorization.

Response Date: _____