Four Corners Periodontics, P.C.
Mark S. Blue, DDS
Practice Limited to Periodontics,
Including Dental Implants

MUTUAL COMMITMENTS TO FINANCIAL AND APPOINTMENT ISSUES

We feel that mutual commitments by you and our practice to financial and time-management issues are important in achieving our goal of establishing long-lasting, meaningful relationships with the people that seek us for treatment. Breaking financial and time agreements between people demonstrates lack of respect by the guilty party and violates important principles that exist to ensure success in any endeavor.

COMMITMENT TO TIME ARRANGEMENTS

In order to try to meet the scheduling requests of all of our patients, we have established some guidelines for reserving appointment times. Your appointment time is reserved only for you, as we treat only one patient at a time. Many patients need our services and missed appointments affect everyone. Because we appreciate your time, we agree to be diligent in seeing you at your reserved time. So that we may provide care for all of our patients, we request that you give us 48 hours notice to change your reserved appointment time. We reserve the right to charge a $50 fee for appointments that are broken without 48 hours prior notice. Please be on time for your appointment. If you are 15 or more minutes late, we reserve the right to reschedule your appointment.

COMMITMENT TO FINANCIAL ARRANGEMENTS

Payment in full is required at the time services are rendered. We accept Cash, Check, Visa, Master Card, Discover and American Express. We also have a dental finance plan called Care Credit available. Due to the exceptional nature of periodontal disease and the specialized nature of some of its necessary treatments, some dental insurance companies unfortunately do not cover some of the procedures.

We are providers for Delta Dental only. If you have this plan, you will only be required to pay your anticipated portion at the time the service is rendered. We will file your insurance claim for you. After the insurance company pays the benefit, you will be responsible for any remaining balance.

For all other dental insurance plans, as a courtesy to you, we will file your claim and submit any information they may need to assist you in collecting your individual insurance assignments. Your dental carrier will then send all estimates or payments directly to you. Your dental insurance exists as a private agreement between you and your dental insurance company to assist you with some of your dental expenses.

While we will be diligent in assisting you in interpreting your potential insurance benefits, our treatment recommendations will be made solely on sound science and physiological principles and not with individual insurance recommendations in mind. We feel that treating patients otherwise violates our mission of providing our patients the highest standard of care. In return for our commitment to treating you, we expect a similar commitment in your timely payment for services rendered. In the event that our contracted collection agency must be involved with your account, you will be held responsible for not only the balance with us, but also the charges from the collection agency and any attorney fees.

Patient Name:_____

Patient Signature or Guardian:_____

Date: _____

Initials_____

Patient Information

Chief Complaint (Reason for Visit)_____
Who Referred You to Our Office:_____

Patient's Name _____
(Last) (First) (Middle Initial)

Address _____
(Street and Number) (City) (State & Zip)

Phone Numbers ( ) _____ ( ) _____ ( ) _____
(Home) (Work) (Cell)

Social Security Number: _____ **Date of Birth:** _____

Email Address _____**Contact Preference:** ❒ Text OR ❒ Email

Sex: ❒Female ❒Male **Marital Status:** ❒ Married ❒ Single **Occupation**:_____

Parent/Guardian Emergency/ Spouse Information

Parent/Guardian/Emergency/Spouse _____
(Last) (First)

Address _____
(Street and Number) (City) (State & Zip)

Phone Number ( ) _____

Insurance Information

Do you have Dental Insurance: ❒ No ❒ Yes

Primary Subscriber: _____Date of Birth_____Member ID #_____

Insured's Employer:_____Group Number:_____

Insurance Company: _____ **Phone Number** ( ) _____

Claims Address:_____

Dental History

Previous Periodontal Therapy? ❒ yes. ❒ no
Fear of Dental Treatment ❒ yes. ❒ no
Type of Periodontal Therapy

_____

_____

Date of Therapy_____

Initials_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

Initials_____

Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following

Are you under the care of a physician now? If yes, please provide name and phone #:	○ Yes ○ No	If yes
Have you seen a physician within the last 2 years? If yes, provide date:	○ Yes ○ No	If yes
Have you been hospitalized or had a major operation? If yes, for what and the date:	○ Yes ○ No	If yes
Do you have Diabetes? Type I or Type II (circle one) / If yes, Last hbA1C test results:	○ Yes ○ No	If yes
Do you have an Artifical / Prosthetic Joint Replacement? If yes, Date of Procedure:	○ Yes ○ No	If yes
Do you need PREMEDICATION for Artificial / Prosthetic Joint? If yes, Type of Antibiotic:	○ Yes ○ No	If yes

Please indicate any conditions that my apply to you:

☐ HIV/AIDS	☐ COPD	☐ Chronic Bronchitis	☐ Emphysema
☐ Hepatitis A/B/C/D (circle type)	☐ Cirrhosis	☐ High Blood Pressure	☐ High Cholesterol
☐ Anemias	☐ Heart Attack	☐ Congestive Heart Failure	☐ Heart Trouble/Disease
☐ Cardiac Arrhythmias	☐ Angina	☐ Stroke	☐ Heart Pacemaker
☐ Heart Valve Replacement	☐ Congenital Heart Disease with prosthetic	☐ Mitral Valve repaired with an Annuloplas	☐ Palliative shunts and conduits
☐ Leukemia	☐ Lupus	☐ Cancer	☐ Radiation Treatment
☐ Chemotherapy	☐ Kidney Disease	☐ Liver Diease	☐ Jaundice
☐ Tonsillitis	☐ Sinus Trouble	☐ Stomach Ulcers	☐ Gastrointestinal Disease
☐ Acid Reflux	☐ GERD	☐ Thyroid Disease	☐ Parathyroid Disease
☐ Immunologic Diseases	☐ Rheumatoid Arthritis	☐ Adrenal Disease	☐ Pituitary Disease
☐ Urinary Disease	☐ Cold Sores/Fever Blisters	☐ Herpes	☐ Psoriasis
☐ Neurologic Disorders	☐ Fainting Spells/Dizziness	☐ Depression/Mood Disorders	☐ Anxiety
☐ Drug Addition	☐ Insomnia	☐ Epilepsy/Seizures	☐ Pulmonary Edema
☐ Asthma	☐ Shortness of Breath	☐ Eye Problems	☐ Ear Problems
☐ Muscular Problems	☐ Jaw Joint Problems	☐ Hemophillia	☐ Bleeding Disorders
☐ Osteoporosis	☐ Fear of Dental Treatment		

Medications

Are you currently taking any medictions? If yes, please list below: ○ Yes ○ No

Are you allergic to any of the following:

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics
☐ Tetracycline	☐ Other		

Type of Reaction (please circle all that apply): Itching / Hives Upset Stomach Breathing Difficulty

Initials_____

Do you use any of the following: If you marked yes, Please indicate daily usage below:

Chewing Tobacco	Yes / No	Cigarettes	Yes / No	Cigars	Yes / No	Alcohol	Yes / No

Do you use Marijuana? If yes, indicate frequency of use:

☐ Recreational ☐ Medical

Women: Are you...

☐ Pregnant/Trying to Get Pregnant ☐ Nursing ☐ Taking Oral Contraceptives ☐ Menopause

Have you taken Bisphosphonates for Osteoporosis? Yes / No If yes
Ex: Fosamax or Actonel. If yes, which one
If yes, indicate how long:

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:

X Date:_____

Sleep Questionnaire

Indicate if you have the following symptoms and how frequently they occur

Rarely or never (0) Frequently (2)
Some of the time (1) Often or most of the time (3)

- I am sleepy during the day though I have slept through the night _____
- I fall asleep when watching TV even though I try to stay awake _____
- I have fallen asleep during routine situations _____
- I have been told that I snore loudly even when sleeping on my side _____
- I have been told that I stop "breathing" at night _____
- I wake up at night and cannot go back to sleep no matter how hard I try _____
- I have been told that I grind or clench my teeth when sleeping _____

Consent for Treatment

To the best of my knowledge the information enclosed is complete and correct. I hereby give permission for dental treatment to be accomplished and for photographic recordings of the conditions and treatment for the advancement of Dental Science.

Signature (patient,parent or guardian)	Date

Initials_____