# PATIENT INFORMATION FORM

**CHARLES B. FELTS, III DDS, MSD**
*Diplomate of American Board of Periodontology*

**ELIZABETH FELTS RANDALL, DMD, MS**
*Diplomate of American Board of Periodontology*

Name: Dr. /Mr. /Mrs. /Ms. ______________________________________________

**(Circle One)** **First** **Middle** **Last**

**Preferred Pharmacy:** ________________________________________

Address: ____________________________

City:_____________ State: _____ Zip: ______

DOB: _____/_____/______ Age: ________

Social Security #: ______-______-________

Employer: ____________________________

Occupation: ____________________________

Cell Phone: ( ) -

Home Phone: ( ) -

Work Phone: ( ) -

Email:_______________@_____________

Preferred contact method:

☐ Text ☐ Cell ☐ Home ☐ Work ☐ Email

May we leave you a voicemail? ☐ YES ☐ NO

***Referral Information***

Who referred you to our office?___________________ Name of General Dentist: ____________________

Is another family member or relative a patient at our office? **YES** **NO** Name: ____________________

***Person Financially Responsible for Account***

Name:__________________________________ Relationship to Patient: ____________________

Address: ________________________________________________________________

***Dental Insurance***

Do you have Dental Benefits? (Circle One) **YES** **NO** *If yes, please provide card to be copied.*

Primary Insurance Company: ________________

Employer:____________________________

Employee's Name: ______________________

Employee DOB:______/______/________

Social Security #:______-______-________

Member ID #: __________________________

Secondary Insurance Company: ________________

Employer:____________________________

Employee's Name: ______________________

Employee DOB:______/______/________

Social Security #:______-______-________

Member ID#: __________________________

Please list authorized persons with whom we may discuss your Protected Health Information (PHI). Please notify us if you desire to remove a name from this list in the future.

1. ____________________ Relationship:______________ Phone: ____________

2. ____________________ Relationship:______________ Phone: ____________

**Patient Signature:** ________________________ **Date:** _____/_____/______

**Print Name:** ________________________

CHATTANOOGA PERIODONTICS & DENTAL IMPLANTS

PROVIDING PERIODONTAL HEALTH
ORAL PLASTIC SURGERY AND DENTAL IMPLANTS

CHARLES B. FELTS III, DDS, MSD
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# MEDICAL HISTORY FORM

To Our Patients: Although periodontal surgeons primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important relationship with the care that you will be receiving. Thank you for answering the following questions. Your answers are for our records only and will be kept confidential.

Name: ____________________ DOB: ____________

Height: __________ Weight: ________ Age: ____________

General Health: ☐ Good ☐ Fair ☐ Poor

Are you under the care of a physician? ☐ Yes ☐ No Date Last Seen: ____________

Physician's Name: ____________________

Contact Information: ____________________

Primary Pharmacy & Address: ____________________

| Allergies | Yes | Reaction | Allergies | Yes | Reaction |
|---|---|---|---|---|---|
| Penicillin/Amoxicillin | | | Narcotics | | |
| Sulfa Drugs | | | Ibuprofen/NSAIDS | | |
| Tetracycline/Doxycycline | | | Latex | | |
| Other antibiotics? | | | Local anesthetics | | |
| Other allergies (Please List) | | | | | |
| Has your physician recommended avoiding any medications? (Please List) | | | | | |

| Medical Problems | Yes | No | Details | Medical Problems | Yes | No | Details |
|---|---|---|---|---|---|---|---|
| Heart Problems / Surgery | | | | Kidney Problems / Dialysis | | | |
| Atrial fibrillation / Irregular Heartbeat | | | | Hepatitis / Liver Disease | | | |
| Artificial Heart Valve/ Pacemaker | | | | STD / Venereal Disease | | | |
| Chest Pain / Angina | | | | HIV / AIDS | | | |
| High Blood Pressure | | | | Immune System Disorder | | | |
| Stroke | | | | Arthritis | | | |
| Asthma / Bronchitis | | | | Osteopenia / Osteoporosis | | | |
| COPD / Emphysema | | | | Joint Replacement (Hip, Knee, etc) | | | |
| Pneumonia / Tuberculosis | | | | Acid reflux | | | |
| Sleep Apnea / CPAP | | | | Stomach Ulcers | | | |
| Sinus Problems / Allergies | | | | Healing problems | | | |
| Hearing Impairment | | | | Tumors / Cancer | | | |
| Vision Problems / Glaucoma | | | | Chemotherapy / Radiation | | | |
| Tobacco Use | | | | Epilepsy / Seizures | | | |
| Alcohol/Drug Use | | | | Neurological Disorder | | | |
| Anemia / Sickle Cell | | | | Fainting / Dizziness | | | |
| Abnormal Bleeding | | | | Depression / Anxiety | | | |
| Thyroid Trouble | | | | Pregnant / Nursing | | | |
| Diabetes | | | HbA1c: | Other | | | |

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# MEDICAL HISTORY FORM

| MEDICATIONS: | | | |
|---|---|---|---|
| **Are you now taking?** | **Yes** | **No** | **Details** |
| Blood thinners?<br>(Coumadin, Plavix, Aspirin, Eliquis, Xarelto, Brilinta, Pradaxa etc) | | | |
| Narcotics on a regular basis?<br>(Are you on a pain contract?) | | | |
| SNRI or TCA Antidepressants<br>(Effexor/venlafaxine, Cymbalta/ duloxetine, Pristiq, Elavil/ amitriptyline)? | | | |
| Any natural product, herbal supplement, or homeopathic remedy? | | | |
| Are your taking or have you taken bone density meds, bisphosphonates, RANKL inhibitors such as Denosumab (XGEVA), Prolia, Fosamax, Boniva, Actonel, Zometa, or Reclast in the past 10 years | | | |

| Please list any medications you are currently taking | | |
|---|---|---|
| **Medication** | **Dose** | **Frequency** |
| | | |
| | | |
| | | |
| | | |
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| | | |
| | | |
| | | |
| | | |

- Is there any other condition concerning your health that the doctor should be told about? ☐ Yes ☐ No
  If so, please explain: ____________________________________________
- Has a physician recommended that you take antibiotics prior to dental treatment? ☐ Yes ☐ No
- Have you ever had IV or general anesthesia? ☐ Yes ☐ No
- Have you ever had an unusual or serious reaction to IV or general anesthesia? ☐ Yes ☐ No
  If so, please explain: ____________________________________________

I certify that I have read and understood the questions above. I acknowledge that my questions, if any, have been answered to my satisfaction. I will not hold my doctor, or any other member of the staff, responsible for any errors or omissions that I may have made in the completion of this form.

_________________________________ _________________________

Signature of Patient Date

# CHATTANOOGA PERIODONTICS
# & DENTAL IMPLANTS

## General Consent

The success of periodontal therapy and implant treatment is dependent on many factors including the severity of the periodontal destruction, the patient's general physical status, and the patient's ability and willingness to perform proper oral hygiene and to stay on a recall program after active treatment. Naturally, we will make every effort to keep you informed of your needed treatment. Your involvement and understanding are very important in the long-term success of your periodontal and implant therapy.

Periodontal and implant treatment involves complex procedures, and during the course of treatment unusual and unanticipated problems can arise. I hereby authorize the doctor or designated staff to take x-rays, study models, photographs and any other diagnostic material deemed appropriate by the doctor. I authorize that such diagnostic material may be released to third party payors and/or other health professionals and can be used for professional education without identification. I agree to the use of anesthetics, sedatives and other medications as necessary. I fully understand that using medication has certain risks including: redness, swelling, pain, itching, vomiting, dizziness, drowsiness, miscarriage, cardiac arrest, and/or lack of coordination. During periodontal and implant treatment, possible complications can arise including bleeding, prolonged numbness, and sensitive and/or loose teeth. I understand that I can ask for a complete listing of any possible complications.

I am responsible for payment for all services rendered on my behalf. I understand that payment is due when services are rendered. I am aware that a 1.5% MPR or 18% APR will be automatically tabulated into my account if my balance is 30 days old or older. Should my account become delinquent, I will be responsible for all additional collection costs, including reasonable attorney fees.

I authorize the Practice to release to staff, hospitals, health care service plans, insurance companies, self-insurers or their representatives, any and all information, records, and other diagnostic material about my medical history, services rendered, or recommended treatment.

I authorize the Practice to submit claims for payment for services rendered or pre-authorizations necessary to my insurance company, on my behalf and in my name listed as "signature on file" and assign to the Practice the insurance benefits providing assignment is accepted. I am responsible for payment regardless of coverage provided.

_________________________________      ______ / ______ / ________

Signature      Date

## Acknowledgement of Receipt of Notice of Privacy Practices Pursuant to HIPPA and Consent for Use of Health Information

I received a copy of the Notice of Privacy Practices of Chattanooga Periodontics and Dental Implants in accordance with the Federal requirements of HIPAA. I Hereby authorize, as indicated by my signature below, Chattanooga Periodontics and Dental Implants to use and disclose my protected health information for any necessary clinical, financial, and insurance purpose, as authorized in the General Patient Consent form above.

_________________________________      ______ / ______ / ________

Signature      Date

_________________________________

Print name