# Mark I. Gutt, D.M.D., P.A.

Periodontics • Implantology • TMJ Disorders

*Diplomate of the American Board of Periodontology*

PLEASE FILL OUT COMPLETELY

BP _____

PULSE _____

TO BE COMPLETED BY DOCTOR

LAST NAME | FIRST NAME | RESIDENCE TELEPHONE | SS#

AGE | DATE OF BIRTH | MARITAL STATUS (Married, Single, Widow)

RESIDENCE | CITY | ZIP

BUSINESS NAME | ADDRESS | BUSINESS PHONE

REFERRED BY | NAME OF GENERAL PHYSICIAN | PHYSICIAN'S TELEPHONE

REASON FOR VISIT | E-MAIL ADDRESS

| | Circle One | |
|---|---|---|
| Has there been any change in your general health within the last year? | Yes | No |
| Have you been examined by or are you now under the care of a physician within the last year? | Yes | No |
| If yes, what is the condition for which you are being treated? _____ | | |
| By whom? _____ | | |
| Have you ever had an operation? | Yes | No |
| If yes, what type? _____ | | |
| Have you been hospitalized or had a serious illness during the past 5 years? | Yes | No |
| If yes, what was the problem? _____ | | |

## DO YOU HAVE, OR HAVE YOU HAD ANY OF THE FOLLOWING?

| | | |
|---|---|---|
| Surgery or radiation (x-ray) treatment for a tumor, growth, cancer, or other condition of your head, neck or mouth? | Yes | No |
| Cancer/chemotherapy? | Yes | No |
| Venereal disease? | Yes | No |
| Artificial bones, joints, prostheses (knee or hip replacements, heart valves), or implants? | Yes | No |
| A blood transfusion? | Yes | No |
| Denied permission to give blood? Why? | Yes | No |
| AIDS, ARC, or positive antibody test to HIV-HTLV-III? | Yes | No |
| Addiction to or recovering from any drugs or alcohol? | Yes | No |
| Contact with any individual having hepatitis, tuberculosis, or AIDS? | Yes | No |
| Premedication with antibiotics prior to a dental procedure? | Yes | No |
| Frequent, severe headaches or severe pains of the face or head? | Yes | No |
| Spells of dizziness? Of faint? | Yes | No |
| Continually stuffed up nose? Runny nose? | Yes | No |
| Sinus trouble? | Yes | No |

## DO YOU HAVE, OR HAVE YOU HAD ANY OF THE FOLLOWING?

### CARDIOVASCULAR

| | | |
|---|---|---|
| Rheumatic fever, rheumatic heart disease, growing pains, or twitching of the limbs? | Yes | No |
| Heart murmur, mitral valve problem, or congenital heart disease? | Yes | No |
| Heart trouble, heart attack, stroke, angina, pacemaker, or prosthetic (artificial) heart valve? | Yes | No |
| Irregular heartbeat or arrythmia? | Yes | No |
| Shortness of breath or chest pain after mild exercise? | Yes | No |
| Shortness of breath when you lie down? | Yes | No |
| Use of more than 2 pillows to sleep? For comfort? | Yes | No |
| High or low blood pressure? Which one? _____ | Yes | No |
| Swollen ankles? | Yes | No |

| | Circle One | |
|---|---|---|
| **BLOOD DISORDERS** | | |
| Anemia or sickle cell disease? | Yes | No |
| Do you bruise easily? | Yes | No |
| Do you have a blood clotting disorder? | Yes | No |
| **RESPIRATORY** | | |
| Asthma, emphysema, or difficulty breathing? | Yes | No |
| Tuberculosis? | Yes | No |
| A persistent cough or coughing up blood? | Yes | No |
| **GASTRO-INTESTINAL** | | |
| Do you suffer from stomach trouble? | Yes | No |
| Are there any foods you cannot eat? | Yes | No |
| Do you have frequent diarrhea? | Yes | No |
| A loss or gain of 10 pounds in the past year? | Yes | No |
| Stomach ulcers? | Yes | No |
| Hepatitis, jaundice, or liver disease? | Yes | No |
| **GENITO-URINARY** | | |
| Frequent urination (pass water more than 6 times a day? At night)? | Yes | No |
| Excessive thirst? | Yes | No |
| Kidney trouble or renal dialysis? | Yes | No |
| **WOMEN** | | |
| Are you pregnant or anticipating pregnancy in the near future? | Yes | No |
| Are you taking any birth control pills (oral contraceptives)? | Yes | No |
| Is your menstrual cycle irregular? | Yes | No |
| Have you reached menopause (change of life)? | Yes | No |
| Are you taking any hormones? Which? _____ | Yes | No |
| **ENDOCRINE SYSTEM** | | |
| Diabetes? Is it diet controlled? Oral pills? Insulin? | Yes | No |
| Thyroid disease? Thyroid tablets? | Yes | No |
| Do you get tired easily? | Yes | No |
| **NERVOUS SYSTEM** | | |
| Psychiatric therapy? | Yes | No |
| Nervous breakdown? | Yes | No |
| Seizures, convulsions, or epilepsy? | Yes | No |
| **SKIN** | | |
| Do you bleed excessively after a cut? | Yes | No |
| Skin diseases? (lupus, pemphigus)? Which, if any? _____ | Yes | No |
| Hives or skin rashes? | Yes | No |
| Are you being treated by a dermatologist? If yes, for what? _____ | Yes | No |

*Turn over please*

| | Circle One | |
|---|---|---|
| **BONES AND JOINTS** | | |
| Arthritis? Rheumatism? | Yes | No |
| Swollen joints? | Yes | No |
| Fractures or dislocations? | Yes | No |
| Joint replacements (hip, TMJ)? | Yes | No |
| Gout? | Yes | No |
| **HAVE YOU TAKEN ANY OF THE FOLLOWING DRUGS OR MEDICATIONS IN THE PAST 6 MONTHS?** | | |
| Anticoagulants (blood thinners)–persantin, coumadin, baby aspirin (an aspirin a day), ecotrin? | Yes | No |
| Medicine for high blood pressure or water pills? | Yes | No |
| Cortisone (steroids)? | Yes | No |
| Valium, librium, or tranquilizers? | Yes | No |
| Antidepressants? | Yes | No |
| Aspirin? Advil? Tylenol? Excedrin? | Yes | No |
| Insulin or pills for diabetes? | Yes | No |
| Digitalis, procardia, cardizem, or drugs for heart trouble? | Yes | No |
| Nitroglycerine or other medications for angina (chest or heart pain)? | Yes | No |
| Dilantin or medication for seizures? | Yes | No |
| Medicine not prescribed by an M.D. (ie. over the counter medicine)? Vitamins? | Yes | No |
| Other_____ | Yes | No |
| **ALLERGIES** | | |
| **Are you allergic to or have you had a reaction such as itching, rash, swelling of hands, feet or eyes to:** | | |
| Novocaine or dental anesthetic? | Yes | No |
| Penicillin or other antibiotics? | Yes | No |
| Aspirin? Advil? Tylenol? | Yes | No |
| Codeine or other narcotics? | Yes | No |
| Do you have hay fever? | Yes | No |
| Other_____ | Yes | No |

| | Circle One | |
|---|---|---|
| **ORAL HEALTH HISTORY** | | |
| **Do you have a history of:** | | |
| Fever blisters or "cold sores", recurrent canker sores, mouth ulcers, or herpes infections? | Yes | No |
| Trouble with previous dental treatment? | Yes | No |
| Bleeding excessively after extractions, surgery, or wounds? | Yes | No |
| Frequent dry mouth? | Yes | No |
| Do you have any disease, condition, or problem not listed? | Yes | No |
| If yes, specify:_____ | | |
| **SOCIAL HISTORY** | | |
| Do you smoke? | Yes | No |
| How much per day? _____ | | |
| For how long? _____ | | |
| If ex-smoker, when did you stop? _____ | | |
| Do you drink alcoholic beverages? | Yes | No |
| What?_____ | | |
| How much a day?_____ | | |
| **FAMILY HISTORY** | | |
| Do you have a family history of heart disease, diabetes, immunological or skin diseases (such as lupus, pemphigus)? | Yes | No |
| Do you have any family history of muscular or brain disorders? | Yes | No |

Patient's Signature _____

Date _____

## FINANCIAL ARRANGEMENTS AND INSURANCE

We are committed to providing you with the best possible care. In order to achieve our goal, we need your assistance, and your understanding of our payment policy.

Payment for services is due at the time services are rendered, unless payment arrangements have been approved in advance by our staff. There will be a 1.5% charge added to any bill unpaid by the first of any given month, if a payment plan has not been pre-arranged. Any fees that might be incurred by Mark I. Gutt, D.M.D. in an effort to collect any balances due, including but not limited to, collection agencies, attorneys & court costs will be the patient's responsibility. ***We accept cash, checks, Mastercard, Visa and American Express.***

If you have dental insurance, we are anxious to help you receive your maximum allowable benefits. We will be happy to help you process your insurance claim-form for your reimbursement. Any such request must be accompanied by a completed insurance form at each visit, unless otherwise specified.

You must realize, however, that:

1). Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.

2). Our fees are generally considered to fall within the acceptable range by most companies, and therefore are covered up to a maximum allowance determined by each carrier. Some companies will only pay a percentage or the UCR (usual and customary and reasonable fee for this region).

3). It has been our experience that Medicare does NOT cover any procedure that is done in the mouth.

***We must emphasize that as dental care providers, our relationship with you is with you, not your insurance company.*** While the filing of insurance claims is a courtesy that we extend to our patients, *all changes are your responsibility from the date the service is rendered.* We realize that temporary financial problems may effect timely payments of your account. If a problem does arise, we encourage you to contact us promptly for assistance. Failure to meet payment terms will result in a credit blemish on your permanent credit files.

*WE ARE HERE TO HELP.*

Signature_____