

**PERIODONTAL & IMPLANT ASSOCIATES, INC.**

**315 2<sup>nd</sup> Street S.E**

**Cullman, AL 35055**

**Office #: (256) 734-8588 Fax #: (256)734-6971**

**[www.perioimplantinc.com](http://www.perioimplantinc.com)**

**JENNIFER HIRSCH DOOBROW, D.M.D.**

**Periodontal & Implant Associates, Inc. is not a preferred provider with ANY insurance company, however, we will be happy to file for your DENTAL benefits. We are not signed up with Medicare, Medicaid and All Kids; therefore, we are unable to file with these groups.**

**We welcome you to our office and are excited to be a part of your dental health! We strive as a team to make your visit with us a positive experience.**

We ask that you take the time and fill out these forms COMPLETELY. At the time of your visit we will also need a form of picture I.D. and your current dental benefit cards (if available).

Understanding dental benefits can be confusing and we want our patients to understand that dental benefits are much like medical. All procedures recommended may not be covered by your dental benefits. We recommend that you become familiar with your individual benefits.

The best way to know the 'limits' of your dental benefits is for you to directly contact your dental benefit provider and request a copy of these benefits to be sent to you to keep for your records and knowledge. This helps with unexpected surprises when billing and payments are rendered.

**However, it should be understood that the dental benefit contract is between the company and the patient who bears the ultimate financial responsibility. Payment will be expected at the time of service.**

If you have any questions for our staff, please feel free to contact us.

Our office hours are:

Monday-Thursday *from* 8:00AM-12:00PM *and* 1:00PM-5:00PM.

We look forward to seeing you soon,

Dr. Jennifer Doobrow

# PERIODONTAL & IMPLANT ASSOCIATES, INC.

## FINANCIAL POLICY & INSURANCE BENEFIT DISCLAIMER

We file your insurance as a courtesy for you. This is not a guarantee that the insurance company will pay us or send payment directly to you. The insurance companies pay at their discretion. We have no control over what procedures or amounts they chose to pay. (INITIAL\_\_\_\_\_)

There is no direct relationship between our office and your insurance company. The type of plan chosen by you, and/or your employer determines your insurance benefits. As such, we have no say in the selection of your insurance company, nor control over the terms of your contract, the methods of reimbursement or the determination of your insurance benefits. We are not a preferred provider for any insurance provider. As a courtesy to you, we will file your insurance even if we are not a preferred provider. If you have any questions, please feel free to ask our office manager.

The procedures that we do are in accordance with those recommended by the American Academy of Periodontology.

The procedures that are performed are those which benefit your oral health and are not influenced by insurance companies.

If you have any reservations about treatment pricing please address these with our office manager prior to treatment.

Insurance companies pay on what they have set as their fee schedule and that varies per insurance company. (Example: Most cleanings or dental procedures are paid by their fee schedule not of the actual charged fee by the dentist). (INITIAL\_\_\_\_\_)

You are responsible for any insurance checks that are sent directly to you by forwarding them to us. If they are not received in a timely manner (within 30 days) the full balance becomes your responsibility. (INITIAL\_\_\_\_\_)

We are not a preferred provider; however, we will file for you. (INITIAL\_\_\_\_\_)

If at any time you are not certain what benefits are covered by your insurance company, we ask that you refer to your coverage booklet provided by your insurance company through your employer.

We try to verify all active coverage prior to treatment being performed. Should your coverage become retroactively cancelled or not be in effect at the time of service, the balance becomes your responsibility. (INITIAL\_\_\_\_\_)

We will accept benefits from your insurance company; however, you are responsible for the full balance. Including any amount that is not paid by your insurance company. (INITIAL\_\_\_\_\_)

We will work with you and your insurance company to get all the benefits that are provided for you to the best of our ability. This may require additional information that you may submit to our office. Alternatively, this may require you to contact your insurance company. (INITIAL\_\_\_\_\_)

I give permission to refile or to dispute any unpaid claims on behalf of the claimant and subscriber. (INITIAL\_\_\_\_\_)

I understand that payment in full for services rendered is expected at time of service. When filing insurance, if there are deductibles and copayments I also understand that these are to be paid at the time of service. (INITIAL\_\_\_\_\_)

I have read and fully understand the Financial Policy as presented. Also, the services may or may not be covered by my insurance carrier. Regardless of the payment, lack thereof, in case of retro cancelation or reimbursement of previously paid fees, any unpaid balance becomes my responsibility. I further agree to pay any and all collection cost, attorney fees and court fees that become necessary to collect any unpaid balance. I am also aware that any unpaid balance may be turned over to an outside collection company.

Guardian/Guarantor Signature \_\_\_\_\_ Date \_\_\_\_\_

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**\*PLEASE PRINT OR CIRCLE THE FOLLOWING INFORMATION:**

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Home Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_

Email Address: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Single  Married  Divorced  Widowed  Separated  Male  Female

Whom may we thank for referring you? \_\_\_\_\_ Previous/present Dentist \_\_\_\_\_

Last Dental Visit Date: \_\_\_\_\_ Reason for the visit: \_\_\_\_\_

Other family members seen by us? \_\_\_\_\_

(Please Circle): Employed Retired Student

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

**Spouse or Significant Other Information (if applicable)**

Spouse's Name: \_\_\_\_\_ Spouse's Date of Birth: \_\_\_\_\_

Spouse's Social Security Number: \_\_\_\_\_ Spouse's Cell Phone: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_ Spouse's Work Phone: \_\_\_\_\_

**Account Information**

Person Responsible for Account: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Social Security Number (if different from the patient): \_\_\_\_\_ Phone: \_\_\_\_\_

Address (if different from the patient): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**Fill in below if you need our assistance in maximizing your insurance benefits**

**Primary Dental Insurance (If applicable)**

Insurance Company Name \_\_\_\_\_ Address \_\_\_\_\_

Phone Number \_\_\_\_\_ Insured's Name \_\_\_\_\_

Relationship \_\_\_\_\_ Birth date \_\_\_\_\_ Social Security Number \_\_\_\_\_

Group Number \_\_\_\_\_ ID Number \_\_\_\_\_ Employer \_\_\_\_\_

**Secondary Dental Insurance (If applicable)**

Insurance Company Name \_\_\_\_\_ Address \_\_\_\_\_

Phone Number \_\_\_\_\_ Insured's Name \_\_\_\_\_

Relationship \_\_\_\_\_ Birthdate \_\_\_\_\_ Social Security Number \_\_\_\_\_

Group Number \_\_\_\_\_ ID Number \_\_\_\_\_ Employer \_\_\_\_\_

**Medical Insurance (If applicable)**

Insurance Company Name \_\_\_\_\_ Address \_\_\_\_\_  
 Phone Number \_\_\_\_\_ Insured's Name \_\_\_\_\_  
 Relation \_\_\_\_\_ Birthdate \_\_\_\_\_ Social Security Number \_\_\_\_\_  
 Group Number \_\_\_\_\_ ID Number \_\_\_\_\_ Employer \_\_\_\_\_

**Payment Information**

If you have dental insurance we will be happy to file it for you. However, we do require that you pay the portion of each visit that is not covered by your insurance at the time that the service is rendered. If the amount covered is unknown we require you to pay the estimated portion of 50% at the visit.

How do you plan to pay today's visit? Cash  Check  Credit Card  Type of Card \_\_\_\_\_

You agree, in order for us to service our account or to collect any amounts you may owe, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. Methods of contact may include pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

It is understood that I, or we, will be responsible for all charges incurred on this account, to include all present and future services. I do understand that regardless of the insurance coverage that I might have, I am responsible for all cost of collection, including a reasonable attorney's fee and I further hereby waive all rights of exemption as to personal property under the constitution and laws of the state of Alabama. I have read this agreement and do understand its provisions.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Dental History**

Are you currently in pain? \_\_\_\_\_ What brings you to our office? \_\_\_\_\_

How long has this issue been going on? \_\_\_\_\_ When was your last dental visit? \_\_\_\_\_

Have you ever been to a periodontist? \_\_\_\_\_ If yes, what treatment did you have? \_\_\_\_\_

Did you complete the periodontal treatment recommended? \_\_\_\_\_ Do your gums bleed? \_\_\_\_\_

Have you ever had any serious/difficult problems associated with dental work? \_\_\_\_\_

Have you ever had trauma to your face, head or jaw? \_\_\_\_\_

**Do you or have you ever had any of the following:**

	Yes	No		Yes	No
Bleeding or sore gums	_____	_____	Unpleasant taste/bad breath	_____	_____
Frequent blisters mouth/lips	_____	_____	Swelling/lumps in the mouth	_____	_____
Biting cheeks/lips	_____	_____	Clicking or popping in the jaw	_____	_____
Loose teeth	_____	_____	Sensitivity to Hot/Cold/Sweets	_____	_____
Clenching/grinding teeth	_____	_____	Sensitivity to biting/chewing	_____	_____
burning tongue/lips	_____	_____	Shifting of teeth	_____	_____
Ortho treatment (Braces)	_____	_____	Food impaction	_____	_____
Ortho when? _____			Change in the bite	_____	_____
Difficulty opening/closing jaw	_____	_____			

Do you use any of the following? If so, how often?

Brush \_\_\_\_\_ Floss \_\_\_\_\_ Fluoride rinse \_\_\_\_\_ Other rinses \_\_\_\_\_

What type of brush do you use? Manual or Electric (circle one) Brush is: Soft Medium Hard

What type of toothpaste do you use? \_\_\_\_\_ List any other products you use? \_\_\_\_\_

## Medical History

Your Current physical health is: Good\_\_ Fair\_\_ Poor\_\_ Are you currently under the care of a physician? \_\_\_\_\_

If yes, Whom? \_\_\_\_\_ When was your last doctor visit? \_\_\_\_\_

Have you ever been hospitalized? If yes, please explain \_\_\_\_\_

(Women) Are you pregnant? If yes, give the due date \_\_\_\_\_

Have you ever fainted? If yes, when? \_\_\_\_\_ Please explain \_\_\_\_\_

Do you use tobacco in any form? If yes, how much \_\_\_\_\_

Do you consume alcoholic beverages? \_\_\_\_\_ If so, How often? \_\_\_\_\_

List any medications you are allergic to \_\_\_\_\_

Are you allergic to anything else i.e., Latex? \_\_\_\_\_

Are you on a blood thinner? \_\_\_\_\_ If yes, List of medications \_\_\_\_\_

**Are You Currently or Have Ever Taken Any of the Following:**

Please Check Yes/No

	Yes	No
Fosamax	_____	_____
Aredia	_____	_____
Actonel	_____	_____
Boniva	_____	_____
Prolia/Xgeva	_____	_____
IV Zometa	_____	_____
IV Aredia	_____	_____
IV Reclast	_____	_____

If you answered yes to any of the questions above, please read the following:

Because you have been treated previously with Bisphosphonate drugs, you should know there is a significant risk of future complications with dental treatment. Bisphosphonate drugs appear to adversely affect the ability of bone to break down or remodel itself, thereby reducing or eliminating its ordinarily excellent healing capacity. The risk after surgery, especially from extraction, implant placement and other "invasive" procedures might cause mild trauma to the bone. Osteonecrosis of the jaw may result. This is a smoldering, long-term, destructive process in the jawbone that is often very difficult or impossible to eliminate

Your medical/dental history is very important. We must know the medications and drugs that you have received/taken or are currently receiving/taking. An accurate medical history, including names of physicians, is important.

**\*Please CIRCLE YES or NO as to whether you have ever had the following symptoms/problems.**

**Endocrine System**

Frequent Urination, frequent thirst and hunger	YES	NO
Diabetes Type I	YES	NO
Diabetes Type II	YES	NO
Diet Controlled	Diet Plus oral Medicine	
Diet and Insulin	Insulin type and dose _____	
Last Hemoglobin A1C Measurement and Date _____		
Thyroid Disease		
Hypothyroid	Hyperthyroid	

**Autoimmune Disorders**

Lupus	YES	NO
Rheumatoid Arthritis	YES	NO
Scleroderma	YES	NO
Other Autoimmune Related Problems, please explain _____		

**Heart/Blood Vessels**

Hypertension/High Blood Pressure	YES	NO
Hypotension/Low Blood Pressure	YES	NO
Valvular Heart Disease	YES	NO
Artificial Heart Valve	YES	NO
Coronary Heart Disease	YES	NO
Arrhythmia (irregular heartbeat)	YES	NO
Heart Murmur	YES	NO
Congenital Heart Defect	YES	NO
Congestive Heart Failure	YES	NO
Heart Attack	YES	NO
High Cholesterol	YES	NO
Difficulty breathing at rest	YES	NO
Difficulty breathing lying down	YES	NO
Fainting	YES	NO
Dizziness	YES	NO
Chest pain on exertion	YES	NO
Fluid Accumulation in feet/ankles (swelling)	YES	NO
Heart Surgery	YES	NO
Heart Stents	YES	NO
Heart Procedure	YES	NO
Pacemaker	YES	NO
Defibrillator implant device	YES	NO
Rheumatic Fever	YES	NO
Scarlet Fever	YES	NO
Blood thinner	YES	NO
Other heart problems, please explain _____	YES	NO

## Blood/Lymph

Anemia	YES	NO
Sickle cell disease	YES	NO
Thalassemia	YES	NO
Hemophilia	YES	NO
Bleeding problems/clotting problems (free bleeder)	YES	NO
HIV _____ AIDS _____	YES	NO
Venereal Disease	YES	NO
Blood transfusion, if so when	YES	NO
Bruise easily	YES	NO
Frequent nosebleeds	YES	NO
Other blood disorders, please explain _____	YES	NO

## Lungs/Breathing

Tuberculosis (TB)	YES	NO
Asthma	YES	NO
Hay Fever/Seasonal Allergies	YES	NO
Sinus Problems	YES	NO
Productive/Persistent cough	YES	NO
Emphysema/COPD	YES	NO
Chronic Bronchitis	YES	NO
Sleep Apnea _____ C-Pap Machine _____	YES	NO
Snore while sleeping	YES	NO
Other breathing problems, please explain _____	YES	NO

## Cancer

History of Cancer	YES	NO
Type _____		
Chemotherapy _____		
Radiation _____		
Other Treatment _____		
History of Tumors	YES	NO
History of Growths	YES	NO

## Nervous System

Stroke	YES	NO
Seizures/Convulsions, if so what type	YES	NO
Parkinson's	YES	NO
Shingles	YES	NO
Psychiatric Treatment, if so for what	YES	NO
Temporary weakness of part of the body	YES	NO
Temporary difficulty speaking	YES	NO
Generalized muscle weakness	YES	NO
History of anxiety or panic attacks	YES	NO
Dizziness/Fainting	YES	NO
Headaches	YES	NO
Numbness/Tingling, if so where _____	YES	NO

**Bone/Joint**

Artificial Joints	YES	NO
Arthritis, type	YES	NO
Chronic lower back pain	YES	NO
Cervical spine diseases	YES	NO

**Stomach/Intestines**

Hepatitis, if so A, B, or C _____	YES	NO
Liver Disease	YES	NO
Jaundice	YES	NO
Gastro-intestinal reflux (GERD)	YES	NO
Chron's disease	YES	NO
Ulcerative Colitis	YES	NO
History of nausea and/or vomiting	YES	NO
Rectal bleeding	YES	NO
Other G.I. procedures (ex. lap-bands, slings, staples etc.) _____		
Other G.I. problems, please explain _____		

**Kidney/Urinary**

Kidney Disease	YES	NO
Renal Failure	YES	NO
On dialysis	YES	NO
Kidney transplant	YES	NO
History of blood in urine	YES	NO
Gout	YES	NO
Stents	YES	NO

**Skin**

History of skin cancer	YES	NO
Eruptions rashes hives	YES	NO
Use of oral retinoic acid for acne	YES	NO
Other skin problems, please explain _____		

**Oral**

Fever blisters/ cold sores	YES	NO
Soreness/Hoarseness in throat	YES	NO

**Eyes and Ears**

Visual Changes	YES	NO
Glaucoma: What kind? _____	YES	NO
Hearing Loss	YES	NO

I understand that the information that I have given today is correct to the best of my knowledge. I understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical or dental status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Signature \_\_\_\_\_ Date \_\_\_\_\_



Please fill out the Name, Address, Phone number and Fax number of the Doctors you see.

Type of Doctor	Name	City	Phone Number	Fax Number
Primary Doctor				
Pharmacist				
Cardiologist (Heart)				
Dermatologist (Skin)				
Endocrinologist (Diabetes)				
ENT (Ear Nose Throat)				
Gastroenterologist (Stomach)				
Hematologist (Blood)				
Nephrologist (Kidney)				
Neurologist (Nerves)				
Oncologist (Cancer)				
Ophthalmologist (Eyes)				
Orthopedist (Bone and Joint)				
Pulmonologist (Lung/Respiratory)				
Rheumatologist (Arthritis)				
Urologist (Urinary)				

Others (Chiropractors,  
Acupuncturist, ect.


PERIODONTAL & IMPLANT ASSOCIATES, INC.

**CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION**

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**SECTION A: PATIENT GIVING CONSENT**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone number: \_\_\_\_\_ Email: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

**SECTION B: TO THE PATIENT-PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.**

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Noticed of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information.

**SIGNATURE**

I, \_\_\_\_\_, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent for your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

**REVOCACTION OF CONSENT**

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will *not* affect any action you took in reliance of my Consent you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.



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doobrowdmd@hotmail.com

Smoking Risk Form

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Please indicate your current status by initialing next to the correct statement below

\_\_\_\_\_ I am a non-smoker and do not use nicotine products. I understand the potential risk of second-hand smoke exposure causing surgical complications.

\_\_\_\_\_ I am a smoker or use tobacco / nicotine products. I understand the risk of surgical complications due to smoking or use of nicotine products.

\_\_\_\_\_ I have smoked and stopped approximately \_\_\_\_\_ months (or) \_\_\_\_\_ years ago.

Any medical or dental surgical procedure carries an element of risk for complications and or failure. Risk factors can vary greatly from patient to patient. Smoking has been documented in the literature to delay wound healing and therefore increase the risks of complications and failure. I am aware that use of tobacco / nicotine products may increase my risk of failure and post-operative complications including but not limited to pain, swelling, infection and potential loss of implants. I acknowledge and fully understand I will be responsible for any added expenses for revisions or prolonged post-operative care.

\_\_\_\_\_  
Patient Name (Printed)

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date