PERIODONTAL & IMPLANT ASSOCIATES, INC.
315 2nd Street S.E
Cullman, AL 35055
Office #: (256) 734-8588 Fax #: (256)734-6971
www.perioimplantinc.com

JENNIFER HIRSCH DOOBROW, D.M.D.
KENNETH E. ROSS, D.M.D.,M.S.D.

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, Dr. Kenneth Ross & Team

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.

CURRENT MEDICATIONS LIST:

Medication	Dosage	Prescribed by	Reason for Taking Medication

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

Endocrine System

Diabetes Type I YES NO

Diabetes Type II YES NO

- ☐ Diet Controlled
- ☐ Diet Plus Oral Medications
- ☐ 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

Sjogren's Syndrome YES NO

Scleroderma

Other Autoimmune Related Problems, please explain_____

_____

Heart/Blood Vessels

Blood thinner- If yes, What medication? _____ YES NO

Stroke, When_____ YES NO

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, When _____ YES NO

High Cholesterol YES NO

Difficulty breathing at rest/lying down YES NO

Fainting- When? _____ 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

Other heart problems, please explain _____ YES NO

Blood/Lymph

Anemia	YES	NO
Sickle cell disease	YES	NO
Thalassemia	YES	NO
Hemophelia	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 _____ Sleep Study _____	YES	NO
C-Pap Machine		
Snore while sleeping	YES	NO
Other breathing problems, please explain _____	YES	NO

Cancer

History of Cancer, Tumor, Growths	YES	NO

Type _____

Chemotherapy _____

Radiation _____

Other Treatment _____

Nervous System

Stroke	YES	NO
TIA	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
Weakness of part of the body	YES	NO
Temporary difficulty speaking	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 Rheumatoid_ Osteoarthritis_ Psoriatic _	YES	NO
Chronic lower back pain	YES	NO
Cervical spine diseases		
Osteoporosis/Osteopenia	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.

Patient Signature _____ **Date** _____

Patient's Name:_____ D.O.B.:____/____/_____

Please fill in ALL of the following information that applies:

TYPE OF DOCTOR:	NAME OF DOCTOR:	LOCATION:	OFFICE NUMBER:	FAX NUMBER:
Primary Doctor				
Pharmacist				
ENT (Ear Nose Throat)				
Cardiologist (Heart)				
Orthopedist (Bone and Joint)				
Endocrinologist (Diabetes)				
Rheumatologist (Arthritis)				
Dermatologist (Skin)				
Pulmonologist(Lung/Respiratory)				
Nephrologist (Kidney)				
Neurologist (Nerves)				
Ophthalmologist (Eyes)				
Oncologist (Cancer)				
Urologist (Urinary)				

Others:(Chiropractors, Acupuncturist, ect...)

PERIODONTAL & IMPLANT ASSOCIATES, INC.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

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: _____

REVOCATION 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.

Signature: _____ Date: _____