North Hills Periodontics
222 S. Clay Street
Zelienople, PA 16063
(724) 453-0234
Charu S. Chandra, D.M.D., M.D.S.
Practice Limited to Periodontics

REGISTRATION AND TREATMENT FORM

Name ____
Last First Middle Initial

Address ____
City State Zip Code

Home Phone (_____)_________________ Work Phone (______)__________________________

Cell Phone(______)__________________________ May we call your work number? Y__ N__

Age____Birthdate____/____/____Single___Married___Widowed___Seperated___Divorced___
Sex ____M____F Soc. Sec.# ______-____-_______ EMAIL ___________________________
Employer___________________________Occupation___________________________________
Business Address____
Whom may we thank for referring you? ____
Emergency Contact______________________________Phone (____)______________________

PRIMARY INSURANCE

Insured______________________________D.O.B.____/_____/_____Soc. Sec.#____-___-_____
Address if different from patient____
City_________________________State________Zip________Phone(____)_________________
Relationship to insured____
Insured Employed by____
Occupation_____________________________Business Phone(___)_______________________
Carrier____Phone(___)___________________
Contract and/or ID#______________________________Group#___________________________

Secondary Insurance

Insured______________________________D.O.B._____/_____/____Soc. Sec.#____-___-____
Address if different from patient____
City_________________________State______Zip__________Phone(____)_________________
Relationship to insured____
Insured Employed By____
Occupation_______________________________Business Phone(____)____________________
Carrier____Phone(____)________________________
Contract/ID#_______________________________Group#_______________________________

DENTAL HISTORY

Reason for today's visit____

Date of last dental visit______________________ Date of last dental x-rays ________________

Check (✓) if you have had problems with any of the following:

___ Bad breath	___Grinding teeth	___Sensitivity to hot
___ Bleeding gums	___ Loose Teeth	___ Sensitivity to sweets
___ Clicking or popping jaw	___ Periodontal treatment	___ Sensitivity when biting
___ Food collection between teeth	___ Sensitivity to cold	___ Sores or growths in mouth

How often do you brush? ___________________How often do you floss? __________________

Any other oral hygiene aids? Please list____

MEDICAL HISTORY

Physician's Name ____________________________________Date of last visit____/____/____

Have you had any serious illnesses or operations? ……………………………...Yes No

Have you ever had a blood transfusion? ……………………………………...Yes No

If yes give approximate date____

Have you been hospitalized recently?………………………………………………Yes No

If so for why? ____

(Women)

Are you pregnant?…………………………………………………………………..Yes No

Nursing?……………………………………………………………….………Yes No

Taking birth control pills?..……………………………….……………………...Yes No

Check (✓) if you have or have had any of the following:

___ Aids	___ Cortisone Treatments	___ Hepatitis	___ Rheumatic Fever
___ Anemia	___ Cough, Persistent	___ High Blood Pressure	___ Scarlet Fever
___ Arthritis, Rheumatism	___ Cough up Blood	___ HIV Positive	___ Shortness of Breath
___ Artificial Heart Valves	___ Diabetes	___ Jaw Pain	___ Skin Rash
___ Artificial Joints	___ Epilepsy	___ Kidney Disease	___ Stroke
___ Asthma	___ Fainting	___ Liver Disease	___ Swelling of Feet/Ankles
___ Back Problems	___Glaucoma	___ Mitral Valve Prolapse	___ Thyroid Problems
___ Blood Disease	___ Headaches	___ Nervous Problems	___ Tobacco Habit
___ Cancer	___ Heart Murmur	___ Pacemaker	___ Tonsillitis
___ Chemical Dependency	___ Heart Problems	___ Psychiatric Care	___ Tuberculosis
___ Chemotherapy	Describe_______________	___Radiation Treatment	___ Ulcer
___ Circulatory Problems	___ Hemophilia	___ Respiratory Disease	___ Venereal Disease

List medications you are currently taking____

____

List Allergies____

Authorization

I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize North Hills Periodontics to obtain or send information regarding my treatment via fax.
I authorize the dentist to release all information necessary to secure the payment of benefits.

I understand that my insurance is an agreement between my insurance company and me. I understand I am financially responsible for all charges and my balance regardless of insurance. I understand that I may incur a 9%APR if my balance goes beyond 60 days.

Signature____ Date ______________________________