NORTH HILLS PERIODONTICS, LLC

Charu S. Chandra, D.M.D., M.D.S.
Practice Limited to Periodontics and Implant Dentistry

REGISTRATION AND TREATMENT FORM

Name _____
Last First Middle Initial

Address _____
Street City State Zip Code

Home Phone ( ) _____ Cell Phone ( ) _____

Work Phone ( ) _____ May we call your work number? Y_____ N _____

Email _____ Social Security # _____-_____-_____

Date of Birth ____/____/_____ Single ____ Married ____ Widowed ___ Separated ___ Divorced____

Emergency Contact_____ Phone ( )_____

DENTAL INSURANCE INFORMATION

Insured _____ Relationship to Insured _____

Social Security/ID # _____ Date of Birth _____/_____/_____

Insurance Company _____ Phone ( )_____

Group # _____Employer _____

SECONDARY DENTAL INSURANCE

Insured _____ Relationship to Insured _____

Social Security/ID # _____ Date of Birth _____/_____/_____

Insurance Company _____ Phone ( )_____

Group # _____Employer _____

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 the dentist to release all information necessary to secure payment of benefits.

I understand that I am financially responsible for all charges and my balance regardless of insurance. I understand that I may incur a 12% APR if my balance goes beyond 60 days.

Signature _____ Date_____

DENTAL HISTORY

Referring Doctor _____Phone ( ) _____

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 yes describe _____		
(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 *Type*____	___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	___Swollen 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 (include vitamins, herbal supplements)

_____

_____

List allergies_____

Signature_____ Date _____