Olde Naples Periodontics
Denise C Gay, D.D.S., M.D.S.
Specializing in Periodontics and Dental Implants
1132 Goodlette Frank Rd N Naples, FL 34102
(239)261-1401
office@oldenaplesperio.com

Patient Information

Name_____ Date: _____

Date of birth: __/__/____ Age:_____ Sex: Male or Female

Email: _____

Cell Phone: (____) _____ Home Phone: (____) _____

Local Address:_____

City:_____ State: _____ Zip Code: _____

Northern Address: _____

City:_____ State: _____ Zip Code: _____

Person Responsible for Account: _____ Relationship: _____

Emergency Contact: _____ Relationship:_____

Phone Number: (____) _____

Name of Dentist: _____How long?_____

Name of Physician: _____How long?_____

Pharmacy:_____Number:_____

Do you have dental insurance? YES or NO If Yes, Social Security:_____

Date of your last dental cleaning _____/_____
Date of your last physician exam _____/_____

Reason for today's visit:_____
How did you hear about us?

- ☐ Referral- By whom? _____
- ☐ Internet
- ☐ Social Media
- ☐ Practice Website
- ☐ Family/Friend/Coworker
- ☐ Other-_____

Medical History

Please answer the following questions by mark (X), by circling, or yes or no to your response to indicate if you have or had any of the following. Though some of the questions may seem unrelated to your gum condition, they are essential in assessing your general health status and resistance, and therefore are important considerations in the diagnosis and treatment of periodontal disease.

- ☐ Cancer-
  Type_____
  - ☐ Chemotherapy
  - ☐ Radiation Therapy
- ☐ Artificial Joints-
  _____
  When?
  _____
- ☐ Angina (chest pain)
- ☐ Artificial Heart Valve
- ☐ Heart Conditions (Heart Murmur, Implant, Heart Attack)
- ☐ Heart Surgery- When?
  _____
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker- When?
  _____
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Hay Fever
- ☐ Stroke- When?
  _____
- ☐ Diabetes
  _____
- ☐ Hepatitis A/B/C
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Thyroid Disease
- ☐ Ulcers (Stomach)
- ☐ Gastrointestinal Disease
- ☐ Anemia
- ☐ Blood Disorders
- ☐ Bruise Easily
- ☐ Excessive Bleeding
- ☐ Arthritis
- ☐ Jaw Joint Pain (TMJ)
- ☐ Rheumatoid Arthritis
- ☐ Epilepsy or Seizures
- ☐ Asthma
- ☐ Emphysema
- ☐ Respiratory Problems
- ☐ Sinus Problems
- ☐ Sleep Apnea
- ☐ Tuberculosis
- ☐ AIDS or HIV Positive
- ☐ HPV
- ☐ Osteoporosis/ Osteopenia
- ☐ Eye Trouble
- ☐ Venereal Disease

Medical Allergies

- ☐ Antibiotics
  - ☐ Penicillin
  - ☐ Amoxicillin
  - ☐ Clindamycin
- ☐ Latex
- ☐ Local Anesthetics
- ☐ Others-_____
  _____

YES or NO Are you under any stress? Social/Business/Marital/Financial
YES or NO Do you use tobacco in any form? How much per day?_____
YES or NO Do you consume alcohol? If so, how many glasses daily? _____
YES or NO Do you take any recreational drugs?
YES or NO Have you experienced any unfavorable reactions to previous dental treatment?
YES or NO Are you aware of clenching, gritting, or grinding your teeth?
If so, when?_____
YES or NO Have you ever been treated for periodontal disease before?
When and by whom? _____
YES or NO Have you had any serious illness or operation?
If so, what and when? _____
YES or NO Are you being treated for any medical problem?
If so, what?_____
YES or NO Are you taking any drugs or medications?
If so, please list: _____
_____
_____
_____

Do you have any condition or problem not listed above that you think we should know about?
_____
_____
_____
_____
_____

WOMEN ONLY

YES or NO Are you pregnant?
YES or NO Are you nursing?
YES or NO Are you taking oral contraceptives?
YES or NO Have you reached menopause?

To my best knowledge, the above information is correct.

_____ _____
Patient Signature Date

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Financial Policy

Thank you for choosing our office as your dental healthcare provider. We are committed to providing you with the highest quality lifetime dental care, so that you may attain optimum oral health. The following is a statement of our financial policy, which we require that you read, agree to, and sign prior to any treatment. Payment is due at the time of service, IN FULL. Our office accepts cash, personal checks, credit cards, and outside patient financing, such as CareCredit.

Do you have dental insurance?

- Our office is out of network with any and all insurance companies.
- We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance is a contract between you, your employer, and your insurance company.
- As a courtesy to you we will help you process all your insurance claims. Please understand that we will submit dental claims after all services, however, it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits determine the amount paid. We will, of course, do all we can to make sure your reimbursement is as accurate as possible.
- If your insurance company has not made a payment within 60 days, we will ask you to contact your insurance company to make sure payment is expected.
- If your insurance claim is denied, you will be responsible for calling our office and informing us of any insurance requests.
- We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to YOU, not our office.
- We ask that you pay the full treatment plan, which is an estimated amount, not covered by your insurance company by cash, checks, credit card and/or CareCredit at the time we provide the service to you.
- We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

We thank you for the opportunity to serve your dental health care needs and welcome any questions you may have concerning your care or our financial policy.

I have read, understood and agreed to the above terms and conditions. I understand that responsibility for payment for dental services provided in our office for myself or my dependants is mine, due and payable at the time services are rendered unless financial agreements have been made. By signing below, you agree to our terms.

_____ _____

Patient Signature Date

DENTAL RECORDS RELEASE FORM

Denise C Gay, D.D.S., M.D.S.
Phone Number: 239-261-1401
Fax Number: 239-261-2854
office@oldenaplesperio.com

Patient's name:_____

Patient's date of birth:_____

To whom it may concern,

I hereby authorize you to release any information or records regarding my dental treatment to Dr Denise C. Gay's office at the above email/address. Please send any current x-rays or any information that would be helpful in my dental treatment.

Thank you for your cooperation.

_____ _____

Patient, Parent or Guardian Signature Date

Digital Image Information: Please send digital x-rays in JPEG FORM.

Olde Naples Periodontics
Denise C. Gay, D.D.S., M.D.S.
Acknowledgement of Receipt of Notice of Privacy Practices

Purpose: This form is used to obtain acknowledgement of receipts of our notice of privacy practices or to document our good faith effort to obtain that acknowledgement.

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____ _____

Signature Date

*Copy of office's Notice of Privacy Practices available upon request