George Quintero, D.D.S., P.C.
Diplomate, American Board of Periodontology
Diplomate, American Board of Oral Medicine
Fellow, Academy of General Dentistry

David G. Quintero, D.M.D., M.S.
Diplomate, American Board of Periodontology
Diplomate, International Congress of Oral Implantologists
Fellow, Institute of Advanced Laser Dentistry

Periodontics • Implants • Sedation • Laser Surgery • Oral Medicine

PATIENT INFORMATION...

First Name_____ M.I._____ Last Name_____ Nickname_____

Sex: ❑ Male ❑ Female Birth Date_____ Age_____ Soc. Sec. #_____ Drivers License #: _____

Street_____ Apt._____ City_____ State _____ Zip_____

Home Tel. (_____) _____ Cell (_____) _____ Have you ever been a patient of our practice? ❑ Yes ❑ No

Referred By_____ _____ Has a family member ever been a patient of our practice? ❑ Yes ❑ No
FIRST NAME LAST NAME

Email: _____ Occupation_____

Employer_____ Bus. Tel. (_____) _____ Personal Payment Type: ❑ Cash ❑ Check ❑ Credit Card

Dentist _____ _____ Tel. (_____) _____
FIRST NAME LAST NAME

Medical Doctor _____ _____ Tel. (_____) _____
FIRST NAME LAST NAME

Preferred Pharmacy_____ Tel. (_____) _____

In case of emergency, please contact _____ Tel. (_____) _____ Relation_____

SPOUSE OR OTHER GUARANTOR INFORMATION (if different from self)...

Name_____ _____ Relation_____ S. S. #_____ Birth Date_____
FIRST NAME LAST NAME

Street_____ Apt._____ City_____ State _____ Zip_____

Tel. (_____) _____ Employer _____ Bus. Tel. (_____) _____

INSURANCE INFORMATION...

Marital Status ❑ Married ❑ Divorced ❑ Widow ❑ Single ❑ Legally Separated

Employed ❑ Full Time ❑ Part Time ❑ Retired ❑ Not

PRIMARY INSURANCE COMPANY...

Insurance Type: ❑ Dental ❑ Medical

Employer_____

Bus. Address_____ _____ _____ _____
ADDRESS CITY STATE ZIP

Bus. Tel. (____) _____ Plan_____

Ins. Co. Name_____ I.D. #_____

Address _____ _____
ADDRESS CITY

_____ _____ Tel. (_____) _____
STATE ZIP

Group #_____ Group Name_____

Insured Party_____ _____ Relation_____
FIRST NAME LAST NAME

Sex: ❑ M ❑ F Birth Date_____ S. S. #_____

Street_____ City_____

State, Zip_____ Tel. (____) _____

SECONDARY INSURANCE COMPANY...

Insurance Type: ❑ Dental ❑ Medical

Employer_____

Bus. Address_____ _____ _____ _____
ADDRESS CITY STATE ZIP

Bus. Tel. (____) _____ Plan_____

Ins. Co. Name_____ I.D. #_____

Address _____ _____
ADDRESS CITY

_____ _____ Tel. (_____) _____
STATE ZIP

Group #_____ Group Name_____

Insured Party_____ _____ Relation_____
FIRST NAME LAST NAME

Sex: ❑ M ❑ F Birth Date_____ S. S. #_____

Street_____ City_____

State, Zip_____ Tel. (____) _____

DENTAL INFORMATION...

Reason for today's visit_____ Are you in pain? ❑ Yes ❑ No How Long?_____ Scale of 1-10 _____

Please indicate any of the following problems by checking off the corresponding box:

- ❑ Gum disease
- ❑ Red, swollen or bleeding gums
- ❑ Loose/shifting teeth
- ❑ Food caught between teeth
- ❑ My teeth are sensitive to: ❑ Hot ❑ Cold ❑ Sweets ❑ Biting
- ❑ Recession
- ❑ Missing Teeth
- ❑ Prolonged bleeding from an injury/extraction
- ❑ Blisters/sores in or around the mouth
- ❑ Swelling/lumps in mouth
- ❑ Toothache
- ❑ Recent infections or sore throat
- ❑ Lost/broken filling(s)
- ❑ Teeth grinding/clenching
- ❑ Broken/chipped tooth
- ❑ Bad breath
- ❑ Burning tongue/lips
- ❑ Other _____

Last dental exam_____ Last dental x-rays_____ Times a day you brush?_____ Times a week you floss?_____

What type of toothbrush bristles do you use? ❑ Soft ❑ Medium ❑ Hard

Hamilton Mill Station • 2098 Teron Trace NE, Suite 600 • Dacula, Georgia 30019
Phone (770) 614-8823 • Fax (770) 614-8824
DrQ@QuinteroPerio.com
www.QuinteroPerio.com

Patient Name_____

MEDICAL HISTORY...

Are you in good health? ❑ Yes ❑ No • Height_____ Weight_____ • Are you under the care of a physician? ❑ Yes ❑ No

Have you been told to take antibiotics prior to dental treatment? ❑ Yes ❑ No Name of Med(s) _____

Have you had any illness, operation, or been hospitalized in the past five years? ❑ Yes ❑ No

Have you ever had general anesthesia? ❑ Yes ❑ No • Have you or a family member, had any unusual or serious reactions to general anesthesia? ❑ Yes ❑ No

Have you ever had any of the following? Please check those that apply:

- ❑ AIDS/HIV positive
- ❑ Alzheimer's Disease
- ❑ Allergies
- ❑ Anaphylaxis
- ❑ Anemia
- ❑ Arthritis/Gout
- ❑ Artificial Heart Valve
- ❑ Artificial Joint
- ❑ Asthma
- ❑ Biphosphonates
- ❑ Blood Disease
- ❑ Blood Transfusion
- ❑ Breathing Problem
- ❑ Bruise Easily
- ❑ Cancer
- ❑ Chemotherapy
- ❑ Chest Pains
- ❑ Cold Sores/Fever Blisters
- ❑ Congenital Heart Disorder
- ❑ Convulsions
- ❑ Cortisone Medicine
- ❑ Diabetes
- ❑ Drug Addiction
- ❑ Easily Winded
- ❑ Emphysema
- ❑ Epilepsy or Seizures
- ❑ Excessive Bleeding
- ❑ Excessive Thirst
- ❑ Fainting Spells/Dizziness
- ❑ Frequent Cough
- ❑ Frequent Diarrhea
- ❑ Fequent Headaches
- ❑ Genital Herpes
- ❑ Glaucoma
- ❑ Hay Fever
- ❑ Head Injuries
- ❑ Heart Attack/Failure
- ❑ Heart Murmer
- ❑ Heart Pace Maker
- ❑ Heart Trouble/Disease
- ❑ Hemophilia
- ❑ Hepatitis A
- ❑ Hepatitis B or C
- ❑ High Blood Pressure
- ❑ Hives or Rash
- ❑ Hypoglycemia
- ❑ Irregular Heartbeat
- ❑ Kidney Problems
- ❑ Leukemia
- ❑ Liver Disease
- ❑ Low Blood Pressure
- ❑ Lung Disease
- ❑ Mitral Valve Prolapse
- ❑ Osteoporosis
- ❑ Pain in Jaw Joints
- ❑ Parathyroid Disease
- ❑ Psychiatric Care
- ❑ Radiation Treatments
- ❑ Recent Weight Loss
- ❑ Renal Dialysis
- ❑ Rheumatic Fever
- ❑ Rheumatism
- ❑ Scarlet Fever
- ❑ Shingles
- ❑ Sickle Cell Disease
- ❑ Sinus Trouble
- ❑ Spina Bifida
- ❑ Stomach/Intestinal Disease
- ❑ Stroke
- ❑ Swelling of Limbs
- ❑ Thyroid Disease
- ❑ Tonsilitus
- ❑ Tuberculosis
- ❑ Tumors or Growths
- ❑ Ulcers
- ❑ Venereal Disease
- ❑ Yellow Jaundice
- ❑ Other:

_____

_____

• Do you use tobacco? ❑ Yes ❑ No Frequency_____ • Do you use smokeless tobacco? ❑ Yes ❑ No

• Do you use or have a history of using controlled/illicit substances? ❑ Yes ❑ No Sobriety date _____

• Women: Are you ❑ Pregnant/Trying ot get pregnant? ❑ Nursing? ❑ Taking oral contraceptives?

MEDICATION & ALLERGIES...

Are you now taking:

Y	N		Y	N		Y	N		Y	N	
❑	❑	Nerve pills	❑	❑	Pain killers (including aspirin)	❑	❑	Muscle Relaxers	❑	❑	Stimulants
❑	❑	Diet pills	❑	❑	Tranquilizers	❑	❑	Insulin	❑	❑	Antidepressants

Please list any other medications(s) you are taking (including natural, herbal or homeopathic products):

MEDICATION	DOSAGE	FREQUENCY	REASON FOR USE

❑ ❑ Blood Thinners (Coumadin, Aspirin, Eliquis, Xarelto)

❑ ❑ Are you taking, or have you ever taken bone density meds, RANKL inhibitors or bisphosphonates such as Denosumab, Fosamax Boniva, Actonel, IV-Zometa, Aredia, Reclast, Prolia, Xgeva, or Evista in the past 12 years?

Are you allergic to, or had a reaction to:

Y	N		Y	N		Y	N		Y	N	
❑	❑	Penicillin	❑	❑	Sulfa drugs	❑	❑	Local anesthetic (numbing med)	❑	❑	Amoxicillin
❑	❑	Sodium pentothal/Vliuym/other tranq.	❑	❑	Asperin	❑	❑	Codeine or other narcotics	❑	❑	Latex
❑	❑	Soy	❑	❑	Eggs/Yolk	❑	❑	Sulfites	❑	❑	**Do you have any known allergies?**

Please list any other medication or antibiotic you are allergic to:

MEDICATION/ANTIBIOTIC NAME	MEDICATION/ANTIBIOTIC NAME

Please list any allergies other than drug allergies:

1-4 below for women only: *(Women note: antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician / gynecologist for assistance regarding additional methods of birth control.)*

1) Is there a possibility of pregnancy? ❑ Yes ❑ No **2)** Expected delivery date:_____

3) Are you nursing? ❑ Yes ❑ No **4)** Are you taking birth control pills? ❑ Yes ❑ No

Patients Name_____ **Date**_____

Please initial each section:

_____I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction, I will not hold my doctor, or any member of his staff, responsible for any errors or omissions that I have made in the completion of this form.

_____I permit the office to communicate with me via text message, email or cell phone at the contact information I provided.

_____**PUBLICATION OF RECORDS**: I authorize that my dental records, slides, x-rays or any other information pertaining to my treatment to be used for the advancement of dentistry and reimbursement purposes. My identity will not be revealed to the general public.

_____**FEES & PAYMENTS:** We make every effort to minimize the cost of your care and will be glad to file any dental insurance you have. We will accept assignment for both primary and secondary insurances. Profesional services are rendered and charged to you and all deductibles and fee amounts not covered by insurance are due at the time of treatment. An estimate of the charge for any procedure or surgery you may require will be given to you upon request. Please remember that insurance is considered a method of reimbursing the patinet for fees paid to the doctor and is not a subsitute for payment. Some companies pay fixed allowances for certain procedures and they pay a percentage of the charge. It is your responsibility to pay the deductible amount as well as any co-insurances or balances not paid by your insurance company. If applicable, you will be responsible for all collection costs, attorney fees and/or court costs.

_____The following signature on file is my authorization for the release of information necessary to process my claim. I assign payment of all dental, medical, and surgical benefits including major medical benefits to which I am entitled to Quintero Periodontics. This assignment will remain in effect until revoked by me in writing.

NOTICE OF PRIVACY PRACTICES: You have the right to read our *Notice Of Privacy Practices* before you decide to sign this consent. Our notice provides a description of our treatment, payment activities, healthcare operations, disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our notice accompanies this consent. We encourage you to read it carefully and completely before signing this consent.
We reserve the right to change our privacy practices as described in our *Notice of Privacy Practices*. If we change our privacy practices we will issue a revised *Notice of Privacy Practices*, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our *Notice of Privacy Practices*, including any revisions at any time by contacting:

Contact Person: Kimberly Grizzard
Address: 2098 Teron Trace N.E., Suite 600, Dacula, GA 30019
Telephone: 770-614-8823 Fax: 770-614-8824 E-Mail: DrQ@QuinteroPerio.com

_____I hereby acknowledge that a copy of the office's *Notice of Privacy Practices* has been made available to me. I have been given opportunity to ask any questions I may have regarding this notice

_____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 to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

_____I hereby authorize the release of all medical information when necessary to other providers rendering medical/dental care, as well as to labs that need my information in order to make a diagnosis or fabricate an appliance necessary for my treatment.

I have read and understand all initialled statements. The following signature confirms acceptance of all policies at Quintero Periodontics.

X_____ X_____ X_____

Signature of patient (Parent or Guardian if Minor) **Reviewed By** **Date**

RIGHT TO REVOKE: You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the contact person listed above. Please understand that revocation of this consent will not affect any actions taken before we received your revocation, and that we may choose to continue your treatment or decline your treatment.