BODNAR PERIODONTICS
Center for Aesthetic Periodontics & Implants

Rocky River
21851 Center Ridge Road #104
Rocky River, Ohio 44116
440-331-3044 • Fax 440-356-7033

Strongsville
13550 Falling Water Road #103
Strongsville, Ohio 44136
440-238-4000 • Fax 440-356-7033

PATIENT INFORMATION

First Name _____

Last Name _____

If Child, Parent's Name _____

Street _____

City _____

State _____

Zip _____

Home Phone _____

Work Phone _____

Cell Phone _____

Email _____

Social Security Number _____

Date of Birth _____ Age _____

Sex _____

Employer _____

If Student, School Name _____

Marital Status _____

If Married, Spouse's Name _____

Emergency Contact _____

Emergency Phone _____

General Dentist _____

Referred By _____

How Did You Hear About Us? _____

Other Family Members in This Practice

_____

_____

Date: _____

PRIMARY DENTAL INSURANCE *

PLEASE PRESENT INSURANCE CARD TO BE PHOTOCOPIED

Subscriber Name _____

Subscriber ID _____

Subscriber SS# _____

Subscriber Date of Birth _____

Relationship if other than self _____

Employer _____

Employer Phone _____

Insurance Company _____

Insurance Group Number _____

Address _____

State _____ Zip _____

Insurance Phone _____

SECONDARY DENTAL INSURANCE *

Subscriber Name _____

Subscriber ID _____

Subscriber SS# _____

Subscriber Date of Birth _____

Relationship if other than self _____

Employer _____

Employer Phone _____

Insurance Company _____

Insurance Group Number _____

Address _____

State _____ Zip _____

Insurance Phone _____

**Bodnar Periodontics is a dental provider and is unable to accept medical insurance, Medicare, and Medicaid.*

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PATIENT INFORMATION

Physician Name _____

Date of Last Physical _____

Reason for Visit _____

Are You Currently under a Physician's Care? _____

Have You Ever Been Hospitalized? _____

Date of Last Dental Visit _____

Date of Last Dental X-Ray _____

If Wearing Dentures, Age of Dentures _____

Ever had Novocaine or other local anesthetic?

☐ Yes ☐ No

Are you taking or have taken steroid or cortisone therapy?

☐ Yes ☐ No

Are you taking or have taken any Oral Bisphosphonates? (Fosamax, Boniva, Actonel)

☐ Yes ☐ No

Are you taking or have taken any IV Bisphosphonates? (Aredia, Zometa, Bonefos)

☐ Yes ☐ No

Have you taken antibiotics prior to dental procedures in the past?

☐ Yes ☐ No

Are you a smoker? (If so, how much do you smoke? Or, how long ago did you quit?) _____

☐ Yes ☐ No

Are you pregnant?

☐ Yes ☐ No

If pregnant, your estimated delivery date? _____

Are you currently nursing?

☐ Yes ☐ No

Please list all medications that you are allergic to:

_____

_____

_____

Have you had an adverse reaction or become ill to penicillin, aspirin, codeine, local anesthetics, latex, metals, or any other medication or substance?

☐ Yes ☐ No

Please list all medications that you are currently taking.

_____

_____

_____

Do you currently take Fish Oil, Vitamin E, Omega 3, Plavix, Coumadin, Xarelto or Aspirin daily?

☐ Yes ☐ No

Consume more than one alcohol based drink daily?

☐ Yes ☐ No

Do you have any of the following problems with your mouth or teeth? (Please check all that apply)

☐ Swollen Gums
☐ Bleeding Gums
☐ Gums Burn or Feel Raw
☐ Tooth Sensitive to Cold
☐ Tooth Sensitive to Hot
☐ Dry Mouth
☐ Bad Taste
☐ Teeth Feel Loose
☐ Bite Feels Funny
☐ Areas Trapping Food
☐ Mouth Ulcers
☐ Jaw Joints Click or Pop

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MEDICAL INFORMATION

☐ AIDS/HIV	☐ Alcoholism	☐ Allergies or Hives	☐ Anemia
☐ Arthritis	☐ Artificial Heart Valve	☐ Artificial Joint	☐ Aspirin Therapy
☐ Anticoagulant Therapy	☐ Asthma	☐ Blood Transfusion	☐ Breathing Problems
☐ Cancer	☐ Chemotherapy	☐ Depression	☐ Diabetes
☐ Dialysis	☐ Drug Addiction	☐ Epilepsy or Seizures	☐ Excessive Bleeding
☐ Fainting or Dizziness	☐ Heart Murmur	☐ Heart Disease/Attack	☐ Heart Problem
☐ Hepatitis A (Infectious)	☐ Hepatitis B (Serum)	☐ Hepatitis C	☐ High Blood Pressure
☐ Implant (any type)	☐ Kidney Disease	☐ Latex Allergy	☐ Liver Disease
☐ Lung Disease	☐ Mitral Valve Prolapse	☐ Mouth Sores/Growths	☐ Nervousness
☐ Pace Maker/Heart Surgery	☐ Pain in Jaw (TMJ)	☐ Psychiatric Treatment	☐ Radiation Treatment
☐ Rheumatic Fever	☐ Sinus Problems	☐ Stroke	☐ Teeth Grinding
☐ Teeth Clenching	☐ Thyroid Disease	☐ Transplant (any type)	☐ Tuberculosis (TB)
☐ Ulcers/Stomach Problems	☐ Use of Tobacco Products	☐ Venereal Disease	☐ Other _____

SERVICES REQUESTED

Bodnar Periodontics provides the following services, what are you interested in?

☐ Dental Implants	☐ Treatment of Periodontal Disease	☐ Gummy Smile Reduction
☐ Crown Lengthening	☐ Gentle and Thorough Teeth Cleaning	☐ Laser Assisted Therapy
☐ Cosmetic Gum Lifts	☐ Extractions Prior to Implants	☐ Frenectomy
☐ Treatment of Recession	☐ Aesthetic Soft Tissue Grafts	☐ Biopsy

FOR OFFICE USE ONLY

Medical History Update or Changes

Comments _____

Patient Signature _____ Date _____

Dental Staff Member Signature _____ Date _____

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PAYMENT OPTIONS

At Bodnar Periodontics, we understand that affordability is an important consideration in getting the dental treatment you need and deserve. We offer a variety of payment options so that your treatment is within reach. If you think you may be interested in one of our payment programs, please contact our office for additional information.

AUTHORIZATION AND RELEASE

I certify that I have read and understand the information completed to the best of my knowledge. The questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release my information, including diagnosis and the records of any treatment or examination rendered to me or my dependent during the period of such dental care to third party payers and/or health practitioners.

I authorize and request my insurance company to pay directly to Bodnar Periodontics insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services and any remaining balance will be my sole responsibility. I agree to be responsible for payment of all services rendered on my behalf or any dependents. If I have a change in my health, I will inform Bodnar Periodontics of this at the next appointment.

HIPAA PATIENT CONSENT The Health Insurance Portability and Accountability Act

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment for third-party payers.
- Conduct Normal healthcare operations such as quality assessments and physician certification.

I have been informed by Dr. Bodnar of your Notice of Privacy Practices (located in the patient reception area) containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact the office at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my request restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Signature of Patient or Guardian _____ Date _____

Signature of Physician _____ Date _____