PERIODONTAL MEDICINE
Surgical Specialists, LLC
Personalized | Preventative | Predictable | Proven

GEORGE MANDELARIS | DDS, MS, FACD, FICD
BRADLEY DEGROOT | DDS, MS
www.periodontalmedicine.org
(630) 627-3930

Oakbrook Terrace
1s224 Summit Ave
Suite #205
Oakbrook Terrace, IL 60181

Glenview
2300 Lehigh Ave
Suite #210
Glenview, IL 60026

PATIENT INFORMATION				
Patient's Last Name	First	Middle	☐ Mr. ☐ Mrs.	☐ Sr.
			☐ Dr. ☐ Miss	☐ Jr.
Street Address		City	State	Zip Code
Birth Date	**Age**	**SSN**	**Marital Status**	**Sex**
/ /			☐ Single ☐ Mar ☐ Widow ☐ Div	☐ M ☐ F

DENTAL INSURANCE INFORMATION				
Occupation	Insured Employer			
Insured Employer Address				
Please indicate insurance company	Address of insurance carrier		Phone number	
Insured Name	Insured SSN	Insured ID	Policy Group #	Eff. date
				/ /
Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other			**Insured Birth Date:** / /	

MEDICAL INSURANCE INFORMATION				
Occupation	Insured Employer			
Insured Employer Address				
Please indicate insurance company	Address of insurance carrier		Phone number	
Insured Name	Insured SSN	Insured ID	Policy Group #	Eff. date
				/ /
Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other			**Insured Birth Date:** / /	

FAMILY PHYSICIAN INFORMATION

Primary Doctor's Name	Specialty	Phone Number	City	State	Zip Code
Other Doctor's Name	**Specialty**	**Phone Number**	**City**	**State**	**Zip Code**

RESTORATIVE DENTIST INFORMATION

Doctor's Name		Phone Number	
Street Address	**City**	**State**	**Zip Code**

Whom may we thank for referring you? ☐ Doctor/Dentist ☐ Family/Friend ☐ Other

ALLERGIES (LIST KNOWN ALLERGIES AND REACTIONS TO DRUGS/MEDICATIONS)

☐ Penicillin ☐ Sulfa Drugs ☐ Clindamycin ☐ Local Anesthetic ☐ Barbiturates, sedatives
☐ Aspirin ☐ Iodine ☐ Latex ☐ Codeine

☐ NO KNOWN ALLERGIES ☐ NO KNOWN DRUG ALLERGIES
☐ Other known drug allergies, Please list:

☐ Other allergies (food, adhesives, tapes, Band-Aids, etc.), Please list:

☐ Please list type of reaction for allergies indicated:

MEDICATIONS (PLEASE LIST CURRENT MEDICATIONS THAT YOU ARE TAKING: PRESCRIPTION AND OVER-THE-COUNTER)

MEDICATION	DOSE	MEDICATION	DOSE

Alcoholic beverage consumption: ☐ No ☐ Yes
(If yes, # drinks per week:)

Tobacco Usage: ☐ No ☐ Yes
(If yes, # pack(s)/day: Duration:)

Last medical examination:
HEIGHT: WEIGHT:

Women: Are you pregnant? ☐ Yes ☐ No
Are you nursing? ☐ Yes ☐ No

Do you have any problems associated with your menstrual cycle? ☐ Yes ☐ No

Have you ever had sedation or general anesthesia in the past? ☐ Yes ☐ No
If yes, List any complications:

CHIEF DENTAL COMPLAINT?
Are you experiencing pain at this time? ☐ No ☐ Yes, Location: Duration of pain:

Please Indicate Previous Dental Treatment You Have Had:

☐ Surgery ☐ Orthodontics ☐ Treatment w/ Oral Medicine specialist ☐ Endodontics (root canal therapy)

Indicate which of the following you have had or have at present. Check Yes or No for each item			
Arthritis/Rheumatism	☐Yes ☐No	Sinus trouble or Hay fever	☐Yes ☐No
Artificial Joints If yes, Date placed:	☐Yes ☐No	HIV Positive or AIDS	☐Yes ☐No
Asthma If yes, last attack:	☐Yes ☐No	Kidney Trouble	☐Yes ☐No
Diabetes: ☐Type I ☐Type II ☐History of gestational Daily blood sugar: HgA1C: Date:	☐Yes ☐No	Are you currently taking (or have ever taken) a bisphosphonate drug? (Actonel, Fosamax, etc.) Medication: Duration:	☐Yes ☐No
Do you have a cardiac pacemaker?	☐Yes ☐No	Osteoporosis, Osteopenia If yes, T-score: ☐>2.5 ☐1.5-2.5	☐Yes ☐No
Abnormal bleeding, Anemia	☐Yes ☐No	Epilepsy, Neurological Disorders	☐Yes ☐No
Cardiovascular Disease (heart trouble, heart attack, angina, coronary insufficiency/occlusion, high blood pressure, arteriosclerosis, stroke, valve replacement)	☐Yes ☐No	Diagnosed Sleep Apnea Do you use a CPAP or BIPAP machine?	☐Yes ☐No ☐Yes ☐No
Cancer If yes, Type: Treatment received: ☐Radiation ☐Chemotherapy ☐Surgery	☐Yes ☐No	Stomach Problems ☐Acid Reflux ☐Heartburn ☐GERD ☐Ulcer	☐Yes ☐No
Liver Disease, Hepatitis, or jaundice	☐Yes ☐No	Psychological disorders/Mental Health Problems	☐Yes ☐No
Respiratory problems, emphysema, bronchitis, etc.	☐Yes ☐No	Tuberculosis or persistent cough	☐Yes ☐No
Do you wear contact lenses?	☐Yes ☐No	Sexually transmitted diseases:	☐Yes ☐No
Low blood pressure	☐Yes ☐No	Thyroid disorders: Hypo/Hyper/Other:	☐Yes ☐No

Do you have any first degree relatives with a history of Diabetes? If yes, what type?
☐Mother ☐Father ☐Brother ☐Sister Type:

I certify that I have read and understand the 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 dentist, or any other member of their staff, responsible for any errors that I have made in the completion of this form.

x	/ /
Patient/Guardian Signature	Date (mm/dd/yy)

It is sometimes necessary to consult with other healthcare related professionals and/or institutions in order to have the best information concerning your oral health. This form gives your authorization to requsest pertinent records about your past medical and dental history.

I hereby authorize any physician, dentist, or facility that has any record or knowledge of my health to give Periodontal Medicine & Surgical Specialists, LTD. any such information. A photographic/digital copy of this authorization shall be valid as original.

I understand that any balance over 60 days past de will be subject to a 1% per month finance charge and that I may be liable for any third party collection and/or attorney fees icurred in collecting the delinquent balance.

x	/ /
Patient/Guardian Signature	Date (mm/dd/yy)

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PATIENT CONTACT INFORMATION

Name: _____ **Date:** / /

I give my permission to be contacted on the phone numbers and/or email addresses listed below:

Home Phone: ☐ Preferred contact
Messages may be left regarding: ☐ Appointments ☐ Treatment ☐ Account Status

Cell/Mobile Phone: ☐ Preferred contact
Messages may be left regarding: ☐ Appointments ☐ Treatment ☐ Account Status

Work Phone: ☐ Preferred contact
Messages may be left regarding: ☐ Appointments ☐ Treatment ☐ Account Status

Email: ☐ Preferred contact
Messages may be left regarding: ☐ Appointments ☐ Treatment ☐ Account Status

Information regarding appointments/treatment/account status may be discussed with:

Name: **Relationship:**

Name: **Relationship:**

PHARMACY

Pharmacy Name: Pharmacy Phone Number:

Pharmacy Address:

EMERGENCY CONTACT

In the event of an emergency, please list the names and telephone numbers of two individuals you would like us to contact:

Emergency Contact (primary)

Name: Relationship:

Home Phone: Cell Phone: Work Phone:

Emergency Contact (secondary)

Name: Relationship:

Home Phone: Cell Phone: Work Phone:

Patient Signature Date: / /

Office use only

Reviewed and Witnessed by: Position: Date: / /

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ACKNOWLEDGMENT OF OUR NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of Periodontal Medicine and Surgical Specialists, LTD. Notice of Privacy Practices. By signing below I am "only" giving acknowledgment that I have received or have had the opportunity to receive the Notice of our Privacy Practices.

Patient Name (Print): _____ Date: _____

Signature: _____

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ACKNOWLEDGMENT OF OUR NOTICE OF FINANCIAL POLICY AND INSURANCE LIABILITY PROCEDURES

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of Periodontal Medicine and Surgical Specialists, LTD. Policies: 1) Office Financial Policy and Procedures and 2) Notice of Insurance Liability Form. By signing below I am acknowledging that I have received or have had the opportunity to receive these documents and give my consent for treatment to be billed as stated within.

Patient Name (Print): _____ Date: _____

Signature: _____

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SARS-CoV-2 CORONAVIRUS WAIVER FOR ORAL HEALTH CARE TREATMENT

At Periodontal Medicine & Surgical Specialists, infection control, safety standards, informed consent and credentialing policies have been put in place that exceed what is required of traditional community-based dental practice. Periodontal Medicine and Surgical Specialists, LLC is considered an essential business within the current General Executive Orders of the State of Illinois regarding the Covid-19 pandemic. Periodontal Medicine and Surgical Specialists, LLC practices comply with the Illinois Department of Public Health recommended policies and procedures required during the current Covid-19 pandemic. Periodontal Medicine and Surgical Specialists, LLC practices and procedures comply with American Dental Association and American Academy of Periodontology recommendations for the practice of dentistry and the specialty of Periodontology during the Covid-19 pandemic.

I understand that all reasonable measures have been taken to ensure that my safety is at the highest level possible in the dental office setting, including all personal protective equipment necessary to reduce my risk of contracting a contagious disease. Irrespective to these measures, it is not possible to reduce my risk to zero, primarily as a result of aerosolization which is produced in a dental environment. I understand and accept this risk and consent to allow Periodontal Medicine & Surgical Specialists LLC to proceed with treatment recommendations that have been made to manage my oral health.

I,_____,understand that by receiving oral health care I am placing myself at higher risk for contracting the SARS-CoV-2 virus. I accept this risk and hold Periodontal Medicine and Surgical Specialists LLC (and all of its employees) harmless should I contract the SARS-CoV-2 virus. The possible consequences of contracting SARS-CoV-2 virus range from being a completely asymptomatic carrier (who could unknowingly infect others) to development of severe respiratory disease which may require hospitalization, ventilation and result in death.

Signature: _____ Date: _____

Witness: _____ Date: _____