



O'Neal Periodontics, PC

Laser Periodontics & Dental Implants

A. Cheria O'Neal D.M.D, M.H.S.

1225 Johnson Ferry Road • Suite 760 • Marietta, Georgia 30068 • 770.971.5375

We do not accept Medicare or Medicaid.

Patient's Name		Patients Social Security Number	
Primary Dental Insurance Company			
Primary Dental Insurance Company's Mailing Address		Phone	Group #
Policy Holder's Name			
Social Security Number or ID of Policy Holder		Date of Birth	
Policy Holder's Employer			
Secondary Dental Insurance Company			
Secondary Dental Insurance Company's Mailing Address		Phone	Group #
Policy Holder's Name		Relationship to Patient	
Social Security Number or ID of Policy Holder		Date of Birth	
Policy Holder's Employer			

1. We are not a participating provider in any dental plan, however, we will submit your insurance pre-treatment estimate to your insurance provider at your request.
2. If you do not wish to give your Social Security Number, you may choose to be a cash patient and pay at the time of service. We will provide you with a complete form to file your claim.
3. If you want us to file insurance on your behalf, please provide all requested insurance information before services are performed. We will collect your portion due at the time of service and file your insurance claim. After the insurance portion is paid, we will send a statement for any balance remaining. This balance will be due at receipt of statement.

Assignment of insurance benefits:

I hereby authorize payment directly to **A. Cheria O'Neal DMD, MHS** of any and all insurance benefits and I authorize release of information requested by the patient's insurance company.

Signature _____ Date _____

A. CHERIA O'NEAL, D.M.D., M.H.S.

Practice Limited to Periodontics

1225 Johnson Ferry Road, STE. 760

PHONE (770) 971-5375

Marietta, GA 30068

FAX(770) 971-7926

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

NAME: _____

SECTION B: TO THE PATIENT-PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

PURPOSE OF CONSENT: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

NOTICE OF PRIVACY PRACTICES: You have the right to read our notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. Upon request, a copy of our notice accompanies this consent. We encourage you to read carefully and completely before signing this consent.

RIGHT TO REVOKE: You will have the right to revoke this consent at any time by giving us written notice of revocation. Please understand that revocation of the consent will not affect any action we took in reliance in this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

I, _____, have received a copy of this office's Notice of Privacy Practices. I have had full opportunity to read and consider the contents of this consent form and 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.

PRINT NAME: _____

SIGNATURE: _____

DATE: _____

HEALTH HISTORY

Name _____ Date of Birth ____/____/____ Occupation _____
 Address _____ SS# _____
 City _____ State _____ Zip _____
 Phone (Home) _____ (Work) _____ (Cell) _____
 Your General Dentist's Name _____ Phone _____
 Your Medical Physician's Name _____ Phone _____
 Referred By _____ Emergency Contact _____
 Responsible Party _____ Address _____ Phone _____

Please Circle "YES" or "NO" After Each Question

1. Are you in good health now? YES NO
 a. Has there been any change in your general health within the past year? YES NO
2. My last physical examination was on _____
3. Are you now under the care of a physician? YES NO
 a. If so, what is the condition being treated? _____
4. Have you ever been hospitalized or had a serious illness within the past five (5) years? YES NO
 a. If so, what was the problem _____
5. Joint Replacement: Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? YES NO
 If yes, Physician _____ Phone _____ Date _____
6. Do you have or have you had any of the following diseases or problems?
 - a. Rheumatic fever or rheumatic heart disease? YES NO
 - b. Congenital heart lesions. Mitral valve prolapse or valve replacement YES NO
 - c. Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke? YES NO
 - 1) Do you have pain in chest upon exertion? YES NO
 - 2) Are you ever short of breath after mild exercise? YES NO
 - 3) Do your ankles swell? YES NO
 - 4) Do you get short of breath when you lie down, or do you require extra pillows when you sleep? YES NO
 - d. Sinus trouble YES NO
 - e. Asthma or hay fever YES NO
 - f. Hives, skin rash or shingles YES NO
 - g. Epilepsy (fainting spells or seizures) YES NO
 - h. Diabetes YES NO
 - 1) Do you have to urinate more than six times a day or night? YES NO
 - 2) Are you thirsty much of the time? YES NO
 - 3) Does your mouth frequently become dry? YES NO
 - 4) Has anyone in your family had diabetes? YES NO
 - i. Autoimmune disease? YES NO
 - j. Rheumatoid arthritis? YES NO
 - k. Systemic lupus (erythematosus)? YES NO
 - l. Hepatitis, jaundice or liver disease? YES NO
 - m. Arthritis? YES NO
 - n. Thyroid condition or goiter? YES NO
 - o. Stomach ulcers? YES NO
 - p. Kidney trouble? YES NO
 - q. Tuberculosis? YES NO
 - 1) Have you a persistent cough? YES NO
 - 2) Have you ever coughed up blood? YES NO
 - r. Nervous breakdown? YES NO
 - s. Venereal disease? YES NO
 - t. Tested positive for HIV or AIDS? YES NO
 - u. Cancer/chemotherapy/radiation treatment? YES NO
 - v. Do you have any disease, condition or problem not listed above? YES NO

Please explain: _____

7. Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease?..... YES NO
8. Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?..... YES NO
9. Have you had abnormal bleeding associated with previous extractions, surgery or trauma?..... YES NO
 a. Have you ever had a blood disorder or anemia? YES NO
 b. Have you ever required a blood transfusion?..... YES NO
 If so, explain the circumstances _____
10. Have you ever had surgery or x-ray treatment for a tumor, growth or other condition of your mouth or lips?..... YES NO
11. Have you ever had any severe or rapid weight changes?..... YES NO
12. Are you presently taking any of the following? (Please list below)
- a. Antibiotics YES NO
 b. Sulfa drugs..... YES NO
 c. Anticoagulants (blood thinners ie. aspirin, coumadin, plavix) YES NO
 d. High Blood Pressure Medication YES NO
 e. Cortisone (steroid) YES NO
 f. Cholesterol Medication YES NO
 g. Tranquilizers YES NO
 h. Insulin, tolbutamide (orinase) or similar drugs YES NO
 i. Digitalis, or drugs for heart trouble..... YES NO
 j. Nitroglycerin..... YES NO
 k. Codeine YES NO
 l. Thyroid Medication YES NO
 m. Please list all other medications including over-the-counter medications _____
13. Are you allergic or have you reacted adversely to:
- a. Local anesthetics YES NO
 b. Penicillin YES NO
 c. Other antibiotics YES NO
 d. Sulfa Drugs YES NO
 e. Codeine YES NO
 f. Barbiturates, sedatives or sleeping pills..... YES NO
 g. Aspirin..... YES NO
 h. Iodine YES NO
 i. Latex YES NO
 j. Other _____
14. Do you smoke or use chewing tobacco (circle): cigarettes, cigars, pipe, chewing tobacco YES NO
15. Have you had any serious trouble associated with any previous dental treatment?..... YES NO
 If so, please explain _____
16. Have you ever had previous periodontal treatment? YES NO
 Previous Periodontist: _____ Phone Number: _____

WOMEN

17. Are you pregnant?..... YES NO
 If yes, name and phone number of OB-GYN _____
18. Do you have any problems associated with your menstrual cycle?..... YES NO
19. Are you taking oral contraceptives?..... YES NO

I certify that I have read and understand the above and that the information given on this form is accurate.

Signature _____ Date _____ Signature _____ Date _____
 Signature _____ Date _____ Signature _____ Date _____
 Signature _____ Date _____ Signature _____ Date _____
 Signature _____ Date _____ Signature _____ Date _____