O'Neal Periodontics, PC
Laser Periodontics & Dental Implants

Patient Name: _____
DOB: _____
Name and Address of Physician:
_____
_____

Occupation: _____
General Dentist:_____
Physician Phone Number:
_____
Date of Last Medical Visit: _____

Have you had periodontal disease in the past? Yes No	Have you been told to take antibiotics before dental treatment? Yes No
Have you been hospitalized in the last 5 years? If so, please explain:	Are you presently being treated for any illness or medical condition? If so, please list:

Do you currently have, or have you ever had:

Heart trouble or heart murmur?	Yes	No	IV drugs for osteoporosis/osteopenia?	Yes	No
Chest pain or angina?	Yes	No	Oral drugs for osteoporosis/osteopenia?	Yes	No
Pacemaker?	Yes	No	Diabetes?	Yes	No
High blood pressure?	Yes	No	Thyroid trouble or goiter?	Yes	No
High cholesterol?	Yes	No	Kidney or bladder trouble?	Yes	No
Artificial heart valve?	Yes	No	Hepatitis, jaundice, or liver disease?	Yes	No
Heart attack (myocardial infarction)?	Yes	No	Ulcers or stomach trouble?	Yes	No
Stroke or transient ischemic attack (TIA)?	Yes	No	Fainting or dizziness?	Yes	No
Knee, hip or other joint replacement?	Yes	No	Epilepsy or seizures?	Yes	No
Arthritis?	Yes	No	Depression or anxiety?	Yes	No
Transplant or implant?	Yes	No	Psychological problems?	Yes	No
Tuberculosis?	Yes	No	Drug addiction?	Yes	No
Shortness of breath/lung problems?	Yes	No	Memory loss?	Yes	No
Sinus problems?	Yes	No	Cancer or radiation treatment?	Yes	No
Hay fever or asthma?	Yes	No	Surgery/radiation of growth/condition in mouth?	Yes	No
Glaucoma?	Yes	No	HIV/AIDS?	Yes	No

What drugs/medications do you take or have you taken in the past year? (Please list medications and dosage on next page.)
_____
_____

Do you take any pain medication (aspirin, etc) regularly?	Yes	No	Do you use tobacco? If so, how much?	Yes	No
Do you take any blood thinners?	Yes	No	Do you use recreational drugs?	Yes	No
Have you had abnormal bleeding from dental treatment?	Yes	No	Do you take herbal supplements/vitamins?	Yes	No

Are you allergic to or have you reacted adversely to the following:

Local Anesthetics (Novocaine)?	Yes	No	Codeine or other narcotics?	Yes	No
Aspirin or Ibuprofen?	Yes	No	Nitrous oxide (laughing gas)?	Yes	No
Barbiturates, sedatives, or sleeping pills?	Yes	No	Latex?	Yes	No
Penicillin, tetracycline, sulfa-based drugs or other antibiotics? Please list:	Yes	No	Allergies to other medications? Please list:	Yes	No

Do you have any condition, problem or disease not mentioned above? Yes No If yes, please explain:
_____
_____
_____
_____

Women: Are you pregnant? Yes No Are you taking birth control pills? Yes No

Your comments or concerns:
_____
_____

Patient Signature _____ Date_____

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

If you are taking any prescribed medications, OTC medications, herbal supplements or vitamins, please complete this form.

Name: _____

Date of Birth: _____

I am currently taking the following:

Medication	When I take it	Dose	Other Instructions

☐ I have no medications to list at this time.

_____ _____

Patient or Guardian Signature Date

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Patient's name_____ Date _____
Date of birth _____ Preferred name _____
Name of spouse _____
If a child, parent's name _____
Mailing address_____ Apt # _____
City_____ State_____ Zip _____
Phone: Home (_____)_____ Cell (_____)_____ Work (_____)_____ Ext._____
E-Mail address _____
Employer_____ Position _____
Business address_____
City_____ State_____ Zip_____
Spouse's employer _____
Who may we thank for referring you?_____
Who is your general dentist at this time? _____
Emergency contact _____ Phone _____
Person responsible for payment of account _____
(name,address,telephone if different from above)

Primary Dental Insurance
Your dental insurance is through (check one):
__your employer __your spouse's employer __other
Employee's full name:
_____
Employee's date of birth _____
Employer's name _____
Insurance name _____
Insurance address _____
_____
Employee ID#_____
Group# _____Union local #_____
Insurance company phone (____)_____
Social security # of policy holder_____

Secondary Dental Insurance (if you have dual coverage)
Your dental insurance is through (check one):
__your employer __your spouse's employer __other
Employee's full name:
_____
Employee's date of birth _____
Employer's name _____
Insurance name _____
Insurance address _____
_____
Employee ID#_____
Group# _____Union local #_____
Insurance company phone (____)_____
Social security # of policy holder_____

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 us 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 an approximation of your portion 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 the 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
Marietta, GA 30068

PHONE (770) 971-5375
FAX(770) 971-7926

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

NAME: _____

Who may we discuss your health records with?

Name _____ Relationship _____ Contact Phone _____

Name _____ Relationship _____ Contact Phone _____

Name _____ Relationship _____ Contact Phone _____

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: _____