R. CRAIG DIEDERICH, D.D.S., M.S., P.L.L.C.

PERIODONTICS & DENTAL IMPLANTS

DIPLOMATE OF THE AMERICAN BOARD OF PERIODONTOLOGY

HOURS BY APPOINTMENT

OAK RIDGE OFFICE CENTER
475 E. COLUMBIA AVENUE, SUITE 7
BATTLE CREEK, MI 49015
(269) 964-3931 (800) 444-3931 FAX (269) 964-3699

PATIENT INFORMATION

Last Name _____ First Name _____ M.I. _____
Address _____
Home # _____ Cell # _____ Work # _____
Social Security Number _____ Birthdate _____
Employer _____ Occupation _____
Who may we thank for referring you to our office? _____

Spouse, or if patient is a minor, parent or guardian:
Last Name _____ First Name _____ M.I. _____
Address _____
Home # _____ Cell # _____ Work # _____
Social Security Number _____ Birthdate _____
Employer _____ Occupation _____

DENTAL INSURANCE INFORMATION

Patient's Insurance Company _____
Insured's SSN _____ Group # _____ Phone # _____
Insurance Company Address _____

Spouse, Parent or Guardian's Insurance Company _____
Insured's Last Name _____ First Name _____ M.I. _____
Insured's SSN _____ Group # _____ Phone # _____
Insurance Company Address _____

EMERGENCY INFORMATION

Emergency Contact _____ Relationship _____
Address _____ Phone # _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____.
Name of Insurance Company (ies)
and assign directly to Dr. R. Craig Diederich all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I understand that where appropriate, credit bureau reports may be obtained.

_____ _____ _____
Signature Relationship Date

If you cannot keep your scheduled appointment, we expect you to notify us at least 48 hours in advance. There will be a charge for missed appointments. Office is closed Friday-Sunday.

MEDICAL AND DENTAL HISTORY

Answers to the following questions are for our records and will be considered confidential.

YES NO

☐ ☐ 1. Are you or have you recently been experiencing pain in your mouth or face?
☐ ☐ 2. Do you have any dental condition which you believe requires immediate attention today?
☐ ☐ 3. Do you consider your general health to be good? Approximate date of last physical examination _____
☐ ☐ 4. Are you being treated for any condition by a physician now? What? _____
_____
☐ ☐ 5. Are you now taking any prescription drugs? Which? _____
_____
☐ ☐ Do you take aspirin or aspirin products on a regular basis?
☐ ☐ 6. Are you allergic or have you reacted adversely to any of the following?
- ☐ Local anesthetic (novacaine)
- ☐ Penicillin or any other antibiotics
- ☐ Aspirin
- ☐ Barbiturates (sleeping pills)
- ☐ Codeine
- ☐ Iodine
- ☐ Other _____

☐ ☐ 7. Have you ever had a serious illness or operation?
☐ ☐ 8. Do you take an antibiotic or Pre-med before dental appointments?
☐ ☐ 9. Have you ever had any of the following? Please check which one(s)

- ☐ Rheumatic Fever
- ☐ Heart Murmur
- ☐ Mitral Valve Prolapse
- ☐ Prosthetic Heart Valve
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ High or low blood pressure
- ☐ Bleeding problems or Blood Disorders
- ☐ Congenital Heart Lesions
- ☐ Stroke
- ☐ Blood transfusion
- ☐ Artificial Joint
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Cortisone, hydrocortisone, or ACTH
- ☐ Seizure Disorder
- ☐ Allergy (Hives or Skin Rash) or Hay Fever
- ☐ Diabetes (sugar disease)
- ☐ Kidney or bladder trouble
- ☐ Hepatitis or Liver trouble
- ☐ Jaundice
- ☐ Glaucoma
- ☐ Asthma
- ☐ Tuberculosis
- ☐ Lung Trouble
- ☐ Injury to face or jaws
- ☐ Ulcers
- ☐ Alcoholism
- ☐ Venereal Disease
- ☐ HIV Positive/AIDS
- ☐ Frequent, severe headaches
- ☐ Psychiatric treatment
- ☐ X-ray treatment (radiation therapy)
- ☐ Hearing Impairment or ☐ Visual Impairment

☐ ☐ 10. Are you ever short of breath or do you have chest pain on mild exertion?
☐ ☐ 11. Do you have a persistent cough?
☐ ☐ 12. Have you recently gained or lost weight without dieting? Which? _____
☐ ☐ 13. Have you noticed any recent increased tendency for your skin to bruise?
☐ ☐ 14. Are you thirsty and/or hungry most of the time? Which? _____
☐ ☐ 15. Is there any history of diabetes in your family?
☐ ☐ 16. Do you have frequent canker or cold sores? Which? _____
☐ ☐ 17. Have you ever had an extremely frightening experience with dentistry?
☐ ☐ 18. Do you have a tendency to faint?
19. How frequently do you visit your dentist? _____
20. When did you last have your teeth cleaned? _____
☐ ☐ 21. Have you ever had any teeth extracted? Why? _____
Any associated bleeding or healing problems? _____
☐ ☐ 22. Have you ever had orthodontic treatment (teeth straightened)?

YES NO

☐ ☐ 23. Have you ever had periodontal (gum) treatment? When? _____

☐ ☐ 24. Have you ever had endodontic (root canal) treatment?

☐ ☐ 25. Do you have any removable bridges? How many years? _____ Is it comfortable? _____

26. Who was the first person to mention you may have periodontal disease? _____
When? _____

☐ ☐ 27. Would you be greatly disturbed if you had to lose all your natural teeth and wear false teeth?

☐ ☐ 28. Did either of your parents lose all of their natural teeth?

☐ ☐ 29. Are you dissatisfied with the appearance of your teeth? Why? _____

☐ ☐ 30. Do you have missing teeth that have not been replaced? Why? _____

☐ ☐ 31. Are there any foods you cannot chew? Which? _____

☐ ☐ 32. Have you noticed any loose teeth? Where? _____

☐ ☐ 33. Have any of your teeth recently separated, creating spaces between them? Where? _____

☐ ☐ 34. Does food wedge between any of your teeth? Where? _____

☐ ☐ 35. Are your teeth sensitive to cold, heat or sweets? Which? _____ Where? _____

☐ ☐ 36. Do your gums ever bleed? When? _____

☐ ☐ 37. Have you noticed any bad odors or tastes from your mouth?

☐ ☐ 38. Have you ever had Vincent's infection or trench mouth? When? _____

39. How often do you brush your teeth? _____ times per day? When? _____

☐ ☐ 40. Do you use a hard, medium or soft bristle brush? Which? _____

☐ ☐ 41. Do you use Dental Floss, rubber tip, or Stimudents daily? Which? _____

☐ ☐ 42. Do you use anything else to clean your teeth? If so, what? _____

☐ ☐ 43. Have you ever had oral hygiene instruction?

☐ ☐ 44. Does your jaw click when you chew?

☐ ☐ 45. Is it difficult to open your mouth as wide as you would like?

☐ ☐ 46. Do you ever have pain in the region in front of your ears?

☐ ☐ 47. Do you clench, grit or grind your teeth in the daytime or while you are sleeping?

☐ ☐ 48. Do you have any habits, such as biting your nails, chewing on pipe or pencil, etc.?

☐ ☐ 49. Have you been under more than average nervous tension lately?

☐ ☐ 50. Is your mouth dry in the morning when you awaken?

☐ ☐ 51. Do you breathe through your mouth most of the time?

☐ ☐ 52. Do you smoke or use any tobacco product? What and how much? _____

53. Please circle those foods which you eat daily.

Meats	Bread or Cereal	Dairy Products
Fruits	Vegetables	

☐ ☐ 54. Are you apprehensive about receiving periodontal treatment?

☐ ☐ 55. Is there any health information which was not asked, which you feel may influence dental treatment? _____
What? _____

_____

56. When was the first time you were seen by the referring dentist? _____

WOMEN ONLY

☐ ☐ 57. Are you pregnant or nursing?

☐ ☐ 58. Are you taking birth control pills?

☐ ☐ 59. Have you undergone, or are you undergoing menopause?

PLEASE SIGN AND DATE "ASSIGNMENT AND RELEASE" SECTION ON FRONT OF FORM AND "PATIENT ACKNOWLEDGMENT AND CONSENT" SECTION ON BACK OF FORM.

PLEASE RETURN THIS FORM TO OUR OFFICE PRIOR TO YOUR APPOINTMENT.

THANK YOU.

R. CRAIG DIEDERICH, D.D.S., M.S., P.L.L.C.

Patient Acknowledgement and Consent Form

Effective April 14, 2003, the new federal law known as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that this office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future.

To comply with one of HIPAA's requirements, we are giving you a copy of our Notice of Privacy Practices. This notice of Privacy Practices contains the information that HIPAA requires us to disclose regarding our privacy practices.

Existing Michigan Law requires (in addition to our attempt to obtain your written acknowledgement, discussed above) us to first obtain your written consent prior to disclosing any of your information except for our disclosures in connection with: a defense to a claim challenging our professional competence; a review entity's functions; a claim for payment of fees; a third party payer's examination of our records; a court order as part of a criminal investigation; an identification of a dead body; a licensure investigation; or a child abuse/neglect investigation.

From time to time it may be necessary for us to make disclosures of your information in connection with your treatment. For example, we may make a referral to or consult with another dentist or other health care professional, provide a specimen to a laboratory for testing or otherwise make disclosures of your information in connection with providing or coordinating your treatment.

Patient Acknowledgement & Consent

Please sign this form below to acknowledge that you have today received a copy of our notice of privacy practices and consent to our disclosures of your information that we deem necessary in order to provide you with proper treatment.

I acknowledge that I have today received a copy of the Notice of Privacy Practices. I consent to your disclosures of my information, which you deem necessary in connection with my treatment. I understand that such disclosures may not be the type listed above.

_____ _____

Patient Signature Patient Name (please print)

Date: _____

For office use only

Patient Refused to Sign

The following circumstances prohibited the patient from signing the Acknowledgement:

_____

An emergency situation prevented the patient from signing the Acknowledgement.

_____ _____

Office Personnel (signature) Office Personnel (print name)

Date: _____