L. WAYNE YARBROUGH, D.M.D., P.C.
Practice Limited to Periodontics
1220 Carmichael Way Montgomery, Alabama 36106

PATIENT INFORMATION

PATIENT'S NAME________________________ TODAY'S DATE____________
Home Address________________ City__________ Zip________ Res. Tel.________
Social Security No. ________________ Date of Birth__________ Age______
Marital Status: Single Married Separated Divorced Widowed (Circle One) Cell No. __________
Occupation____________________ Employer Name____________________
Business Address________________ City__________ Zip________ Bus. Tel.________
Spouse's Name________________ Social Security No. ____________ D.O.B.________
Spouse's Occupation ____________ Spouse's Employer____________ Bus. Tel.________
PERSON TO CONTACT IN AN EMERGENCY________________________
Relationship ________________________
Res. Phone ( ) ________________ Bus. Phone ( )________________
PARTY RESPONSIBLE FOR PAYMENT OF ACCOUNT ________________________
Res. Phone ( ) ________________ Bus. Phone ( )________________

IF YOU HAVE DENTAL INSURANCE, PLEASE COMPLETE THE FOLLOWING:

	PRIMARY CARRIER	SECONDARY CARRIER
Insurance Co. Name	____________	____________
Policy No.	____________	____________
Insurance Co. Address	____________	____________
Phone No.	____________	____________

Whom may we thank for referring you?________________________
Reason for this visit________________________

HEALTH HISTORY

For your safety and to assist us in accurately diagnosing and treating you, please carefully review this form completely and fill out all areas which pertain to you.

ALL INFORMATION IS PRIVATE AND CONFIDENTIAL

■ DENTAL HISTORY

Your dentist________________ City____________ How Long ________
Date of last visit__________ Date of last dental cleaning__________ Last F.M. X-rays ________
Check any of the following you have had or currently have:

_____ Mouth Discomfort
_____ Previous Periodontal Treatment
_____ Trenchmouth or Pyorrhea
_____ Gum Abscesses
_____ Gums Bleed when Brushing
_____ Loose or Shifting Teeth
_____Trouble in Chewing or Speaking
_____ Bruise Easily
_____ Grind or Clench your Teeth
_____ Clicking, Popping or Pain in Jaw Joints
_____ Orthodontic Treatment
_____ Sensitive Teeth (heat, cold or sweets)
_____ Awake with Sore Jaws
_____ Mouth Odor or Bad Taste
_____ Cold Sores or Fever Blisters
_____ Other Oral Lesions
_____ Had Immediate Relatives Lose all of their Natural Teeth
_____ Bad Dental Experience
_____ Complications With or Following Previous Dental or Oral Surgical Treatment
_____ Fear of Dental Treatment

____
____

Do you want to keep your teeth?
_____ Yes, no matter how much trouble
_____ Yes, if it's not too much trouble
_____ Don't know
_____ Don't care

I understand that I am financially responsible for all charges on account. We file your insurance claims as a courtesy to our patients. Knowledge of your insurance coverage and policies are the patient's responsibility. Should it become necessary to forward this account for collection, I agree to be responsible for any/all collection costs, attorney fees and /or court costs. I waive now and forever my right of exemption under the laws of the constitution of the State of Alabama and any other state.

____
Authorized Signature

Please continue on reverse side ▶

■ MEDICAL HEALTH HISTORY

1) HOW WOULD YOU DESCRIBE YOUR PRESENT HEALTH? Excellent Good Fair Poor

2) LIST YOUR CURRENT PHYSICIAN(S):

a) ______________________ Type ______________________ How long? __________

b) ______________________ Type ______________________ How long? __________

3) Date of last complete physical exam __________ Purpose ______________________

Findings ______________________ Height __________ Weight __________

	Circle "NO" or "YES"		Explain
4) Are you aware of any changes in your general health in the last year?	NO	YES	______
5) Have you been hospitalized for illness or surgery in the past two years?	NO	YES	______
6) Have you been under a medical doctors care during the past two years?	NO	YES	______
7) Have you ever had excessive bleeding that required special treatment?	NO	YES	______
8) Is there any history of diabetes in your family?	NO	YES	______
9) Are you required to restrict your work activity in any way?	NO	YES	______
10) Are you on a special or restricted diet of any kind?	NO	YES	______

11) DO YOU SMOKE? NO YES How much? __________ How long? __________

12) LIST ALL MEDICATIONS YOU ARE NOW TAKING (include all over the counter).

____

____

13) PLEASE CIRCLE ANY OF THE FOLLOWING MEDICATIONS YOU ARE ALLERGIC TO:

Penicillin	Vibramycin	Novacaine	Tylenol	Codeine	Valium	Other ______
Erythromycin	Sulfa Drugs	Carbocaine	Aspirin	Demerol	Barbiturates	______
Tetracycline	Keflex	Xylocaine	Anesthetics	Morphine	Scopalamine	______

■ **Indicate which of the following you have had or have at present.** Circle "NO" or "YES" to each item.

- Heart Trouble .... NO YES
- Heart Disease or Attack .... NO YES
- Angina .... NO YES
- High Blood Pressure .... NO YES
- Low Blood Pressure .... NO YES
- Heart Murmur .... NO YES
- Rheumatic Fever .... NO YES
- Congenital Heart Lesions .... NO YES
- Artificial Heart Valve .... NO YES
- Scarlet Fever .... NO YES
- Heart Pacemaker .... NO YES
- Heart Surgery .... NO YES
- Shortness of Breath upon Mild Exertion .... NO YES
- Require More than Two Pillows to Sleep .... NO YES
- Ankles Swell .... NO YES
- Anemia .... NO YES
- Sickle Cell Disease .... NO YES
- Artificial Joint (Knee, Hip) .... NO YES
- Kidney/ Bladder Trouble .... NO YES
- Thyroid Disease .... NO YES
- Emphysema .... NO YES
- Persistant Cough .... NO YES
- Tuberculosis .... NO YES
- Asthma .... NO YES
- Hay Fever .... NO YES
- Sinus Troubles .... NO YES
- Allergies or Hives .... NO YES
- Diabetes .... NO YES
- Frequent Thirst and/or Urination .... NO YES
- Stroke .... NO YES
- Epilepsy or Seizures .... NO YES
- Frequent Headaches .... NO YES
- Fainting or Dizzy Spells .... NO YES
- Cancers or Tumors .... NO YES
- Radiation Treatment .... NO YES
- Chemotherapy .... NO YES
- Arthritis/Rheumatism .... NO YES
- Glaucoma .... NO YES
- Contact Lenses .... NO YES
- Hepatitis .... NO YES
- Liver Disease .... NO YES
- Jaundice .... NO YES
- A.I.D.S. .... NO YES
- Blood Transfusion .... NO YES
- Drug or Alcohol Addiction .... NO YES
- Hemophelia .... NO YES
- Venereal Disease .... NO YES
- A Nervous Person .... NO YES
- Ulcers .... NO YES
- Psychiatric Care .... NO YES
- Unintentional Weight Gain/Loss .... NO YES

■ **If Female are you:**

Pregnant? .... NO YES

Taking Birth Control Pills? .... NO YES

Through Menopause? .... NO YES

Taking Hormone Medication? .... NO YES

■ **Do you have any medical condition/diseases not listed above that we should know about?**

NO YES Explain ____

■ ***To the best of my knowledge, all of the preceding answers are true and correct, If I ever have any changes in my health or if my medicines change, I will inform the doctor on or before my next appointment without fail.***

______________________ ______________________

Doctor's Signature Date Patient's Signature Date

Notice of Privacy and Financial Guidelines

Welcome to the office of L. Wayne Yarbrough, Periodontist. Our goal is to offer state of the art treatment at an affordable cost to improve your oral health.

Courtesy Insurance Filing Service:
Our office strives to offer the highest level of care to our patients. We are PPO providers with BCBS, MetLife, United Concordia, and Delta Dental. We base our recommendations on the needs of our patients rather than the limitations of insurance benefits. As a courtesy and convenience to you, we will file your claims for all services and procedures with your dental insurance company. Sometimes your policy will not pay for services, testing or medications that we may feel are medically recommended. Since coverage rules change often, it is not possible for us to always know what your particular coverage may be. We advise you to acquaint yourself with your policy and to call your insurer regarding any coverage questions. We will always work with you to do the best for your health and well-being, and we look forward to sharing the benefit of our years of experience with you.

Payment at Time of Service:
Please provide payment at the time the service or procedure is performed. For your convenience, we accept Visa, MasterCard, Discover, American Express, check, or cash. We will try to estimate your amount after insurance and accept co-payment at the time of service.

Missed Appointments:
If you cannot keep your scheduled appointment, please let us know at least 24 hours in advance. There will be a $25 fee charged for missed appointments without 24-hour notice, except in the case of and emergency.

Fee for Returned Checks:
For checks written in payment for our services, which are returned for insufficient funds, there will be a $25 processing charge.

Questions?
If you have questions about your financial responsibilities or our payment guidelines, please do not hesitate to ask. We look forward to getting to know you and providing the best care available to you.

Dental Insurance Signature on File:
I, the undersigned, have insurance with the carrier named on the information document prepared by me today. I will notify office of any changes to my insurance coverage. I authorize payment of dental benefits directly to Dr. L. Wayne Yarbrough for professional services rendered. I am financially responsible for all charges for such services rendered to me, including the balance remaining after the payment of any insurance benefits. I permit a copy of this authorization to be used in place of the original, and authorize the release of any dental or other information necessary to process a claim on my behalf.

Permission to Treat:
I hereby give Dr. L. Wayne Yarbrough permission to treat me as a patient. I shall comply with his recommendations for treatment, tests and/or referrals to other specialists as may be necessary for my care.

Release of Dental Information:
I authorize the release of any and all dental information necessary to process this claim.

Fax Clearance:
I give my permission to fax any and all records with the understanding that there is a possibility that this information may be misdirected.

Exclusions:
I have listed below the people to whom I **DO NOT** want Dr. L. Wayne Yarbrough to disclose any part of my medical or health information:

____
____
____
____

Notice of Privacy Practices Acknowledgment:
I hereby acknowledge that I have been given a copy of the "Notice of Privacy Practices" for Dr. L. Wayne Yarbrough.

Financial Agreement:
I understand that I am directly responsible for my account, the payment of this account and I hereby assume and guarantee payment of expenses incurred by myself and/or my dependants. Should legal action be required to secure payment of this account, I agree to pay reasonable collection expenses, all court costs and a reasonable attorney's fee incurred thereby.

Compliance Statement:
I have read and I understand the financial guidelines above and I agree to abide by them.

____________________________________ ____________________
Patient or Responsible Party Date