



John C. Udouj, D.M.D.
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General, Cosmetic, Neuromuscular & Sleep Disorder Dentistry

PATIENT & ACCOUNT INFORMATION

Patient Name _____ Male _____ Female _____ Date of Birth _____
Preferred Name _____ SS# _____ Marital Status _____
Who is responsible for the patient's account? _____
Resp. Party: Address _____
Home Phone # _____ Work Phone # _____
Cell # _____ Email address _____
Patient's address & phone (if different from Responsible Party) Phone # _____
Address _____
Patient Employer _____ Address _____ Phone # _____
Where should we call to confirm appointments? ___ Home ___ Work ___ Cell ___ Best time to call _____
Emergency contact: Name _____ Phone _____
Relationship to patient _____
Primary Insurance Coverage* _____ ID# _____ Grp# _____
*Please let receptionist make a copy of Insurance Card(s)
Who carries the Primary Insurance Coverage on patient? _____
SS# _____ DOB _____ Place of Employment _____
Secondary Ins. Coverage _____ ID# _____ Grp# _____
Who carries the Secondary Insurance Coverage on patient? _____
SS# _____ DOB _____ Place of Employment _____
Whom may we thank for referring you to our office? _____

MEDICATIONS

Have you had an adverse reaction to medical or dental treatment or allergic reaction to any medications? ___ Yes ___ No
Explain _____
Have you been hospitalized in the last five years? ___ Yes ___ No Explain _____
Has there been any change in your general health in the last year? ___ Yes ___ No Explain _____
Are you under the care of a physician? ___ Yes ___ No Explain _____
Are you taking any medication at this time (including contraceptives)? ___ Yes ___ No If yes, list _____
Physician's name _____ Phone _____
Preferred Pharmacy _____ Phone _____

PATIENT MEDICAL HISTORY

Do you or have you had any of the following? Check conditions that apply. If yes, explain briefly

<p style="text-align: center;"><i>DIABETES</i></p> <p>Gum disease is a common complication of diabetes. Untreated gum disease makes it harder for diabetics to control blood sugar levels.</p>	<p><i>If you <u>ARE</u> diabetic:</i> ___ Yes ___ No Is your diabetes well controlled? ___ Yes ___ No Hemoglobin Alc Level: _____ Who is your physician for diabetes? _____</p> <p><i>If you <u>ARE NOT</u> diabetic:</i> Is there a family history of diabetes? ___ Yes ___ No (If yes, we urge you to consult with your physician)</p>
<p style="text-align: center;"><i>AIRWAY</i> <i>(Self or Spouse)</i></p> <p>A good night's sleep is necessary for providing physical & mental restoration. An estimated 30% of the adult population suffers from sleep related disorders.</p>	<p>___ Snoring ___ Night Sweats ___ Restless Leg ___ Body Jerks ___ Nightmares ___ Nasal or Septal Deviation ___ Sleep Apnea ___ Obesity ___ Hard to Fall & Stay Asleep ___ Constant Clearing of Throat ___ Mouth breather ___ Lung Disease ___ Sinus Issues ___ Asthma ___ Abnormal Sleep Patterns C-PAP Usage _____</p>
<p style="text-align: center;"><i>ALLERGIES</i></p> <p>It is important to inform Physicians of allergies that can alter your health.</p>	<p><i>Please check all that apply:</i> ___ General Allergies ___ Seasonal Allergies ___ Aspirin ___ Penicillin ___ Sulfa ___ Codeine ___ Metal ___ Latex ___ Local Anesthetics ___ Jewelry (type) _____ Other: _____</p>
<p style="text-align: center;"><i>ORAL HABITS</i></p> <p>Habits can contribute to premature wear and can cause existing dentistry to fail and /or tooth loss.</p>	<p><i>Please check all that apply to your oral habits:</i> ___ Clenching ___ Grinding ___ Unexplained broken or chipped teeth ___ Unexplained chipped or broken crowns ___ Unexplained loss of a tooth or teeth ___ Unexplained need for Root Canal Therapy on one or more teeth <i>List unexplained items:</i> _____</p>
<p style="text-align: center;"><i>GUM DISEASE</i></p> <p>The bacteria which cause gum disease may be spread to a spouse or the family.</p>	<p><i>Has anyone in your immediate family been tested or treated for gum problems?</i> ___ Yes ___ No <i>Circle who:</i> Spouse Mother Father Sibling <i>Have you noticed any of the following signs of gum disease?</i> ___ Bleeding gums during tooth brushing ___ Red, swollen or tender gums ___ Gums that have pulled away from the teeth ___ Persistent bad breath ___ Change in how your teeth fit together ___ Loose or separating teeth ___ Pus between the teeth and gums ___ Food catching between teeth</p>
<p style="text-align: center;"><i>FEMALES</i></p> <p>Females can be at increased risk for gum disease at different points in their life.</p>	<p><i>The following can adversely affect your gums. Please check all that apply:</i> ___ Pregnant ___ Nursing ___ Taking birth control pills ___ Osteoporosis ___ Taking hormone supplements</p>

<p><i>TOBACCO USE</i> Tobacco use is the most significant risk factor for gum disease.</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p><i>HEART PROBLEMS</i> Untreated gum disease can increase your risk for heart attack and stroke.</p>	<p><i>Do you have or have you had other risk factors of heart disease or stroke?</i> <input type="checkbox"/> Heart Attack <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Stroke <input type="checkbox"/> (circle one) High/Low Blood Pressure <input type="checkbox"/> Circulatory Problems <input type="checkbox"/> Pace Maker <input type="checkbox"/> Mitral Valve Prolapse <input type="checkbox"/> Family History of Heart Disease Other (list) _____ If you have any of these other risk factors it is especially important for you to always keep your gums as healthy and inflammation free as possible to reduce your overall risk for heart attack and stroke.</p>
<p><i>HEART MURMUR, ARTIFICIAL JOINT PROSTHESIS</i> Gum inflammation can cause bacteria from the mouth to enter the bloodstream & cause a serious infection of the heart muscle or your artificial joint.</p>	<p><i>Do you have a heart murmur or artificial joint?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No If so, when were you diagnosed or when did you have surgery? _____ <i>Does your physician recommend pre-medication for dental treatments?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what medication? _____ <i>Name & phone # of Physician:</i> _____ _____</p>
<p><i>BLEEDING DISORDERS</i></p>	<p><i>Do you have or have you had any of the following:</i> <input type="checkbox"/> Hepatitis A, B, or C <input type="checkbox"/> Aspirin therapy <input type="checkbox"/> Anemia <input type="checkbox"/> Blood transfusion If yes, when & where _____ <input type="checkbox"/> Coumadin/Blood Thinner <input type="checkbox"/> Hemophilia (Blood clotting disorder)</p>
<p><i>BLEEDING DISORDERS</i></p>	<p><i>Do you have or have you had any of the following:</i> <input type="checkbox"/> Hepatitis A, B, or C <input type="checkbox"/> Aspirin therapy <input type="checkbox"/> Anemia <input type="checkbox"/> Blood transfusion If yes, when & where _____ <input type="checkbox"/> Coumadin/Blood Thinner <input type="checkbox"/> Hemophilia (Blood clotting disorder)</p>

<p>OTHER HEALTH ISSUES</p>	<p><i>Check any that apply to you:</i> <input type="checkbox"/> Cancer <input type="checkbox"/> Chemo/Radiation Treatment <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Venereal Disease <input type="checkbox"/> Immunosuppressive Disease <input type="checkbox"/> HIV-AIDS <input type="checkbox"/> Arthritis <input type="checkbox"/> Ulcer <input type="checkbox"/> Acid Reflux <input type="checkbox"/> Vertigo <input type="checkbox"/> Jaundice or Liver Disease <input type="checkbox"/> Epilepsy or Seizure <input type="checkbox"/> Psychiatric Care <input type="checkbox"/> Depression <input type="checkbox"/> Chemical Dependency <input type="checkbox"/> Swollen Neck Glands <input type="checkbox"/> Tonsils/Adenoid Removal Other (list) _____</p>
<p>APPEARANCE OF YOUR SMILE</p> <p>We offer a variety of ways to improve the look of your teeth.</p>	<p><i>Is it important to you to keep your teeth as long as possible?</i> <input type="checkbox"/> Yes <input type="checkbox"/> Not really</p> <p><i>If you have missing teeth, is there a reason why they have not been replaced?</i> _____</p> <p><i>Do you like the appearance of your teeth?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Do you like the color of your teeth?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Are you interested in whitening your teeth?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No</p>

PATIENT CONSENT FOR USE & DISCLOSURE
of protected health information & policy statement.

With my consent, John C. Udouj, DMD may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations. (TPO). Please refer to Dr. John Udouj's Notice of Privacy Practices (NPP) for a more complete description of such uses and disclosures. I have the right to review the NPP prior to signing this consent. John C. Udouj, DMD reserves the right to revise its NPP at any time. A revised NPP may be obtained by forwarding a written request to our office, attn: Debbie Udouj, Privacy Officer.

With my consent, John C. Udouj, DMD may call my home or other designated location and leave a message on voice mail or with a person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any other call pertaining to my clinical care, including laboratory results among others. Also any items may be mailed to my home or other designated location that assists the practice in carrying out TPO, such as appointment reminders and patient statements. E-mails to my home or other designated locations may also be used to assist the practice in carrying out TPO.

I consent to the taking of photographs, models and x-rays before, during, and after my treatment as they are a necessary part of the diagnostic and record keeping. I further give permission for the use of any/all of these records to be used for the purpose of research, education, or publication.

I have the right to request that Dr. John Udouj's office restrict how it uses my PHI to carry out PTO. However, the practice is not required to agree to my requested restrictions, but if it does, is bound by this agreement. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Dr. Udouj may decline to provide treatment to/for me.

In order to maintain control on billing and bookkeeping expenses, we request that payment in full be made at time of service. If you have dental insurance, we will file your claims as a service to you at no charge. We do require that you pay your estimated portion at the time of service. You will be responsible for any balance remaining after your insurance has paid your claim. All fees are your responsibility. WE MUST EMPHASIZE THAT OUR RELATIONSHIP IS WITH YOU, THE PATIENT, NOT THE INSURANCE COMPANY.

If this account is assigned to an attorney for collection, you will be responsible for the collection fee/suit. I have read the above policies and accept my responsibilities. The information I have provided is accurate and complete to the best of my knowledge. I will not hold John C. Udouj, DMD or any staff member responsible for any errors or omissions that I have made in completing this form. I assigned insurance benefits to which I am entitled to John C. Udouj, DMD. A photocopy of this document is to be considered as valid as the original. I hereby authorize the release of all information to secure payment.

Signature of patient or parent if minor: _____ Date: _____