# Mark E. Glover, D.D.S., M.S.D., P.C.

Board Certified in Periodontics
American Board of Periodontology

## PERSONAL INFORMATION

Today's Date _____

Legal Name: First_____ M.I. _____ Last _____

Name you prefer to be called:_____ DOB _____ /_____ /_____ Age _____

SSN#_____ Driver's License# _____ State issued _____

Height _____' _____" Weight _____lbs. Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Home (_____)_____ Cell (_____)_____ Work (_____)_____, ext#_____

Billing Address _____ City _____ State ___ Zip _____

E-mail address _____

Occupation_____ Employer_____

Name of Spouse or Legal Guardian:

First_____ M.I. _____ Last _____ DOB _____ /_____ /_____

SSN#_____ Occupation_____ Employer_____

Home (_____)_____ Cell (_____)_____ Work (_____)_____, ext#_____

Name of closest relative not living with you _____ Phone (_____)_____

Party responsible for payment of account _____ Phone (_____)_____

Dental Insurance:

Name of Policy Subscriber _____ Company _____

Group#_____ Policy# _____ ID# _____ Phone (_____)_____

None of the services we provide can be filed under medical insurance or under Medicare.
We are not listed as a provider with any insurance carrier, but as long as you have a PPO plan, we are happy to file

Your Physician_____ Phone (_____)_____

Date of last physical _____ Reason for Exam_____

List any specialty care physicians involved in your care, such as cardiologist, oncologist, etc:

Physician_____ Phone (_____)_____

Physician_____ Phone (_____)_____

Who is your Dentist? _____ How Long_____ Date of last exam _____

How often do you see your dentist for cleanings or checkups?_____

How were you referred to our office?

☐ Internet ☐ Friend (Name) _____ ☐ Dentist (Name) _____ ☐ Other _____

Your Pharmacy _____ Location _____ Phone (_____)_____

**8226 Douglas Avenue, Suite 601 Dallas, TX 75225-5928 www.MarkGloverDDS.com**
**Phone: 214-691-5593 Email: scheduling@MarkGloverDDS.com Fax: 214-691-**

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# DENTAL HISTORY

1. ***Tell* us** what concerns you would like Dr. Glover to address today.

2. ***Circle*** any of the symptoms below which may be related to your present condition:

| | | | |
|---|---|---|---|
| Pain | Receding gums | Loose teeth | Sore muscles |
| Bleeding gums | Sore teeth | Changing bite | Spaces between teeth |
| Sore gums | Sensitive teeth | Jaw popping | Bad breath / bad taste |
| Swollen gums | Exposed roots | Other:_____ | |

3. ***Circle*** any of the following that you have now or have ever had:

| | | | | | |
|---|---|---|---|---|---|
| Braces | Gum abscesses | Dental implants | Broken jaw | Root canals | Fever blisters |
| Crowns | Tooth extractions | Bridges | Dentures | Trench mouth | Dry mouth |

4. ***Circle*** any of the following periodontal treatments you have had:

| | | | | |
|---|---|---|---|---|
| Root planing /curettage | Bite adjustments | Antibiotics | Biteguards /splints | Bone grafts |
| Periodontal cleanings | Gum grafts | Gum surgery | | |

Other:_____

5. ***Circle*** any of the following aids you use to clean your teeth:

Toothbrush Toothpaste Water Pik Toothpick Stimudent Floss Mouth rinse Electric brush

6. Can you chew satisfactorily?..... ___Yes ___No
7. Would the loss of your teeth disturb you?..... ___Yes ___No
8. Are you pleased with the appearance of your teeth?..... ___Yes ___No
9. Does your bite feel even?..... ___Yes ___No
10. Do you clench or grind your teeth when stressed or at night?... ___Yes ___No
11. Have you had a frightening experience in a dental office?..... ___Yes ___No
12. Do you have any blood relations who lost all of their teeth?..... ___Yes ___No
13. Do you chew gum, mints, lifesavers or antacids regularly ?..... ___Yes ___No

    * Describe how much/how often: _____

14. Do you eat many candies, cookies, desserts or other sweets?.... ___Yes ___No

    * Describe how much/how often: _____

15. Estimate the number of cups or glasses, etc. you consume each day

    Coffee_____ Tea_____ Soft Drinks _____ Energy Drinks _____ Alcoholic Beverages_____

16. Do you smoke or use tobacco products in any way? ___Yes ___No

    What? _____ How many years? _____ How much per day? _____

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# MEDICAL HISTORY

1. ***Circle*** any of the following you *now have* or have *ever* had and ***draw a line through*** those that do not apply:

| | | | |
|---|---|---|---|
| Rheumatic fever | Stroke | Hepatitis A,B,C, or D | Stomach ulcers |
| Heart murmur or defects | Diabetes | AIDS / ARC | Crohn's Disease |
| Mitral valve prolapse | Hypoglycemia | Herpes | Sjogren's Disease |
| Irregular heart beat | Anemia | Shingles | Alzheimer's Disease |
| Artificial heart valve | Blood transfusion | Arthritis / Rheumatism | Fibromyalgia |
| Chest pain/angina/heart surgery | Sickle Cell Disease | Artificial joint | Headaches / Migraines |
| Heart pacemaker | Kidney problems | Tuberculosis / Lung disease | Glaucoma |
| Heart disease or attack | Bladder problems | Hay fever / Allergies | Allergy to metals |
| High / Low blood pressure | Thyroid problems | Asthma / Emphysema | Latex allergy |
| Systemic Lupus Erythematosus | Prostate problems | Pain in jaw joints | Excessive Thirst |
| Cancer / Leukemia | Seizure Disorders | Bruise easily | Fainting / Dizziness |
| Osteopenia /Osteoporosis | Liver Disease | Depression / Anxiety | Swelling of limbs |

2. ***Circle*** any medications that you have a known allergy or reaction to:

| | | | | | |
|---|---|---|---|---|---|
| Penicillin | Erythromycin | Tetracycline | Doxycycline | Sulfa drugs | |
| Codeine | Morphine | Vicodin | Darvocet | Demerol | |
| Versed | Valium | Halcion | Ativan | Nubain | Fentanyl |
| Aspirin | Tylenol | Ibuprofen | Benzocaine | Xylocaine | |
| None of the Above | | Others (please list): _____ | | | |

3. **Now, place *a star* * beside those medications listed above that you have taken before and would take again.**

4. ***List ALL*** medications/ supplements you are currently taking (pills, drugs, aspirin, vitamins, etc.)

_____

_____

5. ***Circle*** any medications you have taken in the last 12 months other than the ones previously listed:

| | | |
|---|---|---|
| Antibiotics | Blood pressure medication | Tranquilizers / Antidepressants |
| Antihistamine | Stomach ulcer medication | Medications for irregular heart beat |
| Blood thinners | Hormonal therapy | Osteoporosis medication /Bisphosphonates |
| Pain relievers | Cortisone or Steriods | Diet / Weight Loss medications |
| Nitroglycerin | Thyroid tablets | Diabetic medication |
| Aspirin | Recreational drugs | Others_____ |

6. How would you classify your susceptibility to medications? ___ Sensitive ___ Average ___ Resistant

7. List any known food allergies you have: _____

8. Have you been sedated or hospitalized for any reason? ___Yes ___No

List the procedure, year, and any complications. Use the back of this page if necessary

_____

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- Do you have shortness of breath after climbing stairs?..... ___ Yes ___ No
- Do you get up more than one time at night to urinate?..... ___ Yes ___ No
- Do you have excessive thirst or hunger?..... ___ Yes ___ No
- Do you wear contact lenses?..... ___ Yes ___ No
- Have you had abnormal bleeding with previous minor cuts, tooth extractions, or surgery? ..... ___ Yes ___ No
- Do you bruise easily? ..... ___ Yes ___ No
- Have you ever had radiation treatment for a cancer, tumor, growth, or other condition? ..... ___ Yes ___ No
- Have you been in drug or alcohol rehabilitation?..... ___ Yes ___ No
- Are you in a high risk group for contracting AIDS?..... ___ Yes ___ No
- Do you have any other conditions that you feel we ought to be aware of?..... ___ Yes ___ No

  If yes, please explain _____

- WOMEN ONLY: Have you had a baby weighing over 9 pounds at birth? ..... ___ Yes ___ No

  Are you pregnant?..... ___Yes ___No Taking birth control pills? ..... ___ Yes ___ No

  Had a hysterectomy? ... ___Yes ___No Been through menopause? ..... ___ Yes ___ No

If your medical history is more complex or if you would like to provide us with additional information you believe would be helpful, you may use the back of this form to write additional information.

Read and Initial the following statements.

_____ I understand that payment in full is expected at the time services are rendered and that, as a courtesy to me, insurance will be filed on my behalf for reimbursement, with insurance benefits being assigned to Dr. Glover for services rendered, understanding that any overpayment will be refunded to me.

_____ I understand that insurance is intended to defer a portion of my out of pocket expense and that I am ultimately responsible for payment in full for all services rendered, processing fees, lab fees, or cancellation fees.

_____ I understand that, out of respect for Dr. Glover and other patients, 48 hour notice is required for cancellation of appointments. Last minute cancellations or failure to show could result in a fee equivalent to that of the failed appointment; to be evaluated on an individual basis with extenuating circumstances considered

I certify that I have read and understand the information included in this form. I acknowledge that I have had any questions answered to my satisfaction. I will not hold Dr. Glover, or any member of his staff, responsible for any errors or omissions I may have made while completing this form.

Patient's or Guardian's Signature _____ Date _____

Periodontist's Signature _____ Date _____

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# RELEASE OF RECORDS

Dear Dr. _____,

I, _____, hereby authorize the release of my dental records and
(Patient name)
radiographs to the office of Dr. Mark Glover.

Please forward my records and most current radiographs upon receipt of this letter

Please contact Dr. Glover's office if you have any questions.

_____ _____

Patient/Guardian Signature Date

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# Health Insurance Portability & Accountability Act Consent Form (HIPAA)

In an effort to protect your personal information and in compliance with the Health Insurance Portability and Accountability act, we give all patients the ability to obtain a copy of our Privacy Policy. This policy informs you about how your health information is disclosed for treatment operations, payment, lab work, and insurance reimbursement. A copy of our Privacy Policy is always available at your request. Please sign this form as your acknowledgement that this office is following HIPPA policy requirements.

Please initial the following statements:

____ Protected information may be disclosed or used for treatment, payment, and/or healthcare operations.

____ The practice given me the opportunity to read and review the Notice of Privacy Policy

**In order to insure the accuracy of your protected health information, we update this form annually**

Please verify that the contact information below is listed correctly and confirm your contact preferences.

Home Phone: (*The number you listed on page one*) May we leave a message? ___**YES** ___**NO**

Work Phone: (*The number you listed on page one*) May we leave a message? ___**YES** ___**NO**

Cell Phone: (*The number you listed on page one*) May we leave a message? ___**YES** ___**NO**

Email : (*The email address you listed on page one*) May we leave a message: ___**YES** ___**NO**

Billing Address: (*The address listed on page one*) May we send correspondence? ___**YES** ___**NO**

In the event that a family member or caregiver attends my dental visit and is in the exam room at the time of my evaluation or treatment, I give Mark E. Glover, DDS, MSD, PC and his employees my permission to discuss freely, my condition, treatment, financial terms, or diagnosis with that person.

List names of all individuals with whom we may discuss issues relating to diagnosis, treatment, or financial arrangements:

_____

List names & phone numbers of those we may contact in case of an emergency:

_____

Printed name of patient: _____

Patient/Guardian Signature: _____ Date: _____