



# 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# \_\_\_\_\_

Residence Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_

E-mail address \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Name of Spouse: First \_\_\_\_\_ M.I. \_\_\_\_\_ Last \_\_\_\_\_

SSN# \_\_\_\_\_ DOB \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Occupation \_\_\_\_\_

Employer \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_

Name of closest relative not living with you \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

How were you referred you to our office? \_\_\_\_\_

Party responsible for payment of account \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Primary Dental Insurance: Policy Subscriber \_\_\_\_\_ Company \_\_\_\_\_

Group# \_\_\_\_\_ Policy# \_\_\_\_\_ ID# \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Secondary Dental Insurance: Policy Subscriber \_\_\_\_\_ Company \_\_\_\_\_

Group# \_\_\_\_\_ Policy# \_\_\_\_\_ ID# \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Primary Medical Insurance: Policy Subscriber \_\_\_\_\_ Company Name \_\_\_\_\_

Group# \_\_\_\_\_ Policy# \_\_\_\_\_ ID# \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

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 (\_\_\_\_) \_\_\_\_\_

Physician \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Your Pharmacy \_\_\_\_\_ Location \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Your Dentist \_\_\_\_\_ How Long \_\_\_\_\_ Date of last exam \_\_\_\_\_

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



DENTAL HISTORY

1. List all concerns and problems prompted you to make this appointment with Dr. Glover:

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? \_\_\_\_\_



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

Work Phone: (     ) \_\_\_\_\_ May we leave a message?    \_\_\_YES \_\_\_NO

Cell Phone: (     ) \_\_\_\_\_ May we leave a message?    \_\_\_YES \_\_\_NO

Email : \_\_\_\_\_ May we leave a message:    \_\_\_YES \_\_\_NO

Billing Address: \_\_\_\_\_

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 & numbers of those we may discuss issues relating to diagnosis, treatment, and financial arrangements:

\_\_\_\_\_

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

\_\_\_\_\_

Printed name of patient: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_