GULFSIDE
PERIODONTICS

Thomas B. Carter DDS, MBA, MDS
Periodontics | Dental Implant Therapy
Hard & Soft Tissue Regeneration

PATIENT MEDICAL HISTORY

PLEASE PRINT

Patient's Name:	Name of guardian if patient is under the age of 18:		
Address:	Today's Date:	Date of Last Visit:	Date of Med. History:
City, State, Zip:	Birth Date:	Social Security No.:	Marital Status:

Home Phone:	Cell Phone:	Work Phone:	Email:

Name of person who will be paying (if different from patient):	Home Phone:	Work Phone:

Billing Mailing Address (if different from patient's address):	Relationship to Patient:
Physician Name:	Physician Name:
Pharmacy:	Pharmacy Phone:

Do you have Dental Insurance?
❑ Yes ❑ No

Name of Patient or Dentist who referred you to our office: ______________________________

Sex: ______________

If female, please answer the following:
Y N
❑ ❑ Are you taking birth control pills?
❑ ❑ Are you pregnant? If yes, # of weeks ____
❑ ❑ Are you nursing?

Please answer the following:
Y N
❑ ❑ Do you smoke or use tobacco?
For Office Use Only
BP: ____________ Heart Rate: __________

Height: ____________
Weight: ____________

Y N	Conditions	Y N	Conditions	Y N	Conditions	Y N	ALLERGIES
❑ ❑	Alcohol Abuse	❑ ❑	Fainting Spells	❑ ❑	Pneumocystitis	❑ ❑	Aspirin
❑ ❑	Allergies	❑ ❑	Fever Blisters	❑ ❑	Psychiatric Problems	❑ ❑	Codeine
❑ ❑	Anemia	❑ ❑	Frequent Headaches	❑ ❑	Radiation Therapy	❑ ❑	Dental Anesthetics
❑ ❑	Angina Pectoris	❑ ❑	Glaucoma	❑ ❑	Rheumatic Fever	❑ ❑	Erythromycin
❑ ❑	Arthritis	❑ ❑	HIV+ AIDS	❑ ❑	Seizures	❑ ❑	Iodine
❑ ❑	Artificial Bones or Joints	❑ ❑	Hay Fever	❑ ❑	Shingles	❑ ❑	Jewelry
❑ ❑	Artificial Heart Valve	❑ ❑	Heart Attack	❑ ❑	Sickle Cell Disease	❑ ❑	Latex
❑ ❑	Blood Transfusion	❑ ❑	Heart Surgery	❑ ❑	Sinus Problems	❑ ❑	Metals
❑ ❑	Cancer – Chemotherapy	❑ ❑	Hemophilia	❑ ❑	Stroke	❑ ❑	Penicillin
❑ ❑	Colitis	❑ ❑	Hepatitis A	❑ ❑	Thyroid Problems	❑ ❑	Tetracycline
❑ ❑	Congenital Heart Defect	❑ ❑	Hepatitis B	❑ ❑	Tuberculosis	❑ ❑	Other: ____________
❑ ❑	Cosmetic Surgery	❑ ❑	High Blood Pressure	❑ ❑	Ulcers		
❑ ❑	Diabetes	❑ ❑	Kidney Problems	❑ ❑	Venereal Disease		____________
❑ ❑	Difficulty Breathing	❑ ❑	Liver Disease	❑ ❑	Yellow Jaundice		
❑ ❑	Drug Abuse	❑ ❑	Low Blood Pressure	❑ ❑	Abnormal Bleeding/ Hemophilia		____________
❑ ❑	Emphysema	❑ ❑	Mitral Valve Prolapse				
❑ ❑	Epilepsy	❑ ❑	Pacemaker	❑ ❑	Asthma/Allergies/Hay Fever		____________

Thomas B. Carter DDS, MBA, MDS
Periodontics | Dental Implant Therapy
Hard & Soft Tissue Regeneration

PLEASE ✔ Rx OR OVER THE COUNTER

MEDICATIONS or Herbal	QTY.	Rx	O.T.C.	REASON:

Please describe any disease, condition, or problem that you think this office should know about that has not already been listed:

____

____

____

Staff Notes:

____

____

____

____

____

The information on my PATIENT MEDICAL HISTORY is correct and complete to the best of my knowledge. I authorize the release of any medical information by my physician as it pertains to my dental care.

I agree to any X-rays, photography, filming or recording of the procedure to be performed and I authorize release for teaching purposes/publications.

____

Signature of Patient or Legal Guardian Date

#3 Doctors Drive, Ocean Springs, MS 39564 P 228.875.1881 F 228.875.1883
E info@gulfsideperio.com W gulfsideperio.com

Thomas B. Carter DDS, MBA, MDS
Periodontics | Dental Implant Therapy
Hard & Soft Tissue Regeneration

CONSENT FOR DISCLOSURE OF HEALTH CARE INFORMATION

Patient's Name: ______________________________ Date of Birth: ______________

SSN: ______________________ Previous Name: ______________________

Doctor's Name: ______________________________

Practice Name: **Gulfside Periodontics**

My personal health information is private and confidential. I understand that my doctor and his/her staff work very hard to protect my privacy and preserve the confidentiality of my personal health information.

I understand that my doctor and his/her staff may use and disclose my personal health information to help provide health care to me, to handle billing and payment, and to take care of other health care operations. There will be no other uses and disclosures of this information unless I permit it. However, I understand that sometimes the law may require the release of this information without my permission.

I can ask my doctor to limit how my personal health information is used or disclosed to carry out treatment, payment, or health care operations. I understand that my doctor does not have to agree to my request, I understand that my doctor and his/her staff would follow the agreed limits.

I may cancel this consent at any time by doing one of the following:

1. Signing and dating a form that my doctor or his/her staff can give me called “Revocation of Consent for Use and Disclosure of Health Information”; or

2. Writing, signing, and dating a letter to my doctor directly. If I write a letter, it must say that I want to cancel my consent to authorize the use and disclosure of my personal health information for treatment, payment, and healthcare operations.

If I cancel this consent, my doctor and his/her staff do not have to provide any further health care services to me.

My doctor has a detailed document called the “Notice of Privacy Practices.” It contains more information about the policies and practices protecting my privacy. I understand that I have the right to read the “Notice” before signing this agreement. My doctor may update this “Notice.” If I ask, my doctor or his/her staff will provide me with the most current “Notice” and the current “Notice” wilt always be posted at my doctor's office.

My signature below indicates that I have been given the chance to review a current copy of my doctor's “Notice of Privacy Practices”. My signature means that I agree to allow my doctor to use and disclose my personal health information to carry out treatment, payment, and healthcare operations.

______________________________ ______________
Patient Signature Date

____
(Relationship to Patient)

#3 Doctors Drive, Ocean Springs, MS 39564 P 228.875.1881 F 228.875.1883
E info@gulfsideperio.com W gulfsideperio.com

Thomas B. Carter DDS, MBA, MDS

Periodontics | Dental Implant Therapy
Hard & Soft Tissue Regeneration

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

I, ____, have received a copy of this office's Notice of Privacy Practices.

____
Name (please print)

____
Signature

____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

❑ Individual refused to sign

❑ Communication barriers prohibited obtaining the acknowledgement

❑ An emergency situation prevented us from obtaining acknowledgement

❑ Other (please specify)

____

____

____

#3 Doctors Drive, Ocean Springs, MS 39564 P 228.875.1881 F 228.875.1883
E info@gulfsideperio.com W gulfsideperio.com