

**Mountain
Periodontics**
& IMPLANT DENTISTRY
DR. GREGG CODELLI

Welcome to Our Practice!

Please fill out front and back (both pages) and sign as indicated on both back sides.

Patient _____ SSN _____

Spouse's Name _____ Spouse's SSN _____

Patient Date of Birth _____ Spouse's Date of Birth _____

Street Address _____

City/State/ZIP _____

Cell/Mobile _____ Home Ph. _____

Work Ph. _____ Spouse Cell/Mobile _____

email _____ Patient Employer _____

How may we contact you during the day? ☐ cell/mobile ☐ home ☐ work

Patient Diagnostic Information

Who referred you to us? ☐ Dr. _____ ☐ self ☐ Internet/online ☐ other patient _____

In your own words, why does your dentist or you feel you need to see us? _____

Based on what your dentist has told you and what you know about your mouth, please rate the condition of your mouth on a scale of 1 to 10 where 1 is severe disease and 10 is optimal health (circle).

(worst) 1 2 3 4 5 6 7 8 9 10 (best)

Are you in PAIN right now? ☐ YES ☐ NO If yes, does the pain keep you awake at night? ☐ YES ☐ NO

Name & Number of Person To Be Contacted in Case of Emergency, Other Than Spouse:

Name: _____ Phone # _____

When was the date of your LAST DENTAL CLEANING? _____

When was the date of your LAST FULL MOUTH X-RAYS (20 or more films)? _____

Does your doctor require you to pre-medicate with antibiotics prior to dental visits? _____ ☐ YES ☐ NO

Have you had any type of PREVIOUS periodontal/gum therapy (including SCALING/DEEP CLEANING)? ☐ YES ☐ NO

If yes, when and where was periodontal treatment completed? _____

How many times per year do you get your teeth CLEANED? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ occasionally ☐ never

Name, City, Telephone # of Pharmacy _____

Patient Name _____

Statement and Consent to Financial Arrangements

1. Responsibility for payment for professional services provided in this office are due and payable at the time services are rendered.
2. Our practice is not insurance-based, however, we will submit a claim to your insurance provider as a courtesy. Any reimbursement will go to you and not to our practice.
3. It is the patient's (or guarantor's) responsibility to inform the office of any changes in insurance coverage.
4. A nominal fee will be assessed if 24-hour advance cancellation notice for appointments is not given.
5. A 1.5% monthly interest fee will be charged on balances over 30 days due (18% A.P.R.).
6. I authorize the release of all necessary information directly to Mountain Periodontics PC.

Signature of Patient or Guarantor of Account: _____ Date: _____

For Your Information...

1. Dental insurance is not meant to be a "PAY-ALL;" it is meant to be an aid.
2. It has been the experience of many dentists that insurance companies tell their customers that "fees are above the usual and customary fees" rather than saying that "our benefits are too low."
3. We make our recommendations for your well-being based on your dental needs and not on what your insurance may or may not cover.

Dental Insurance

PRIMARY DENTAL

Name of Insurance _____

Subscriber Name & Date of Birth _____

Address (with City, State, ZIP) _____

Phone _____

Group # _____

Member # _____

SECONDARY DENTAL

Name of Insurance _____

Subscriber Name & Date of Birth _____

Subscriber Employer _____

Address (with City, State, ZIP) _____

Phone _____

Group # _____

Secondary Member # _____

Patient Name _____

Mountain Periodontics Medical History (provide details as needed)

Physician's Name and Office Number _____ Date of Last Physical Exam: _____

- Are you in good health? ☐ YES ☐ NO
- Has there been any change in your general health within the year? ☐ YES ☐ NO
- Are you now under a physician's care? ☐ YES ☐ NO
- Have you had any serious illness or operation? ☐ YES ☐ NO
- Have you been hospitalized or had a serious illness within the past 5 years? ☐ YES ☐ NO
- Have you had any history of tumors, malignancies, or treatment for cancer of any nature? ☐ YES ☐ NO
- Do you ever have pain in your chest upon exertion? ☐ YES ☐ NO
- Are you ever short of breath after mild exertion? ☐ YES ☐ NO
- Do you require extra pillows when you sleep or do you get short of breath when you lie down? ☐ YES ☐ NO
- Do your ankles swell? ☐ YES ☐ NO
- Do you have a cardiac pacemaker? ☐ YES ☐ NO
- Have you ever received a blood transfusion? ☐ YES ☐ NO
- Have you had abnormal bleeding associated with previous surgery (any type), extraction or trauma? ☐ YES ☐ NO
- Have you or anyone in your family ever had a problem with sedation or anesthesia? ☐ YES ☐ NO
- Do you use controlled substances? ☐ YES ☐ NO

What MEDICATION(S), if any, are you currently taking (e.g., antibiotics, insulin, aspirin, anticoagulant, medication for high blood pressure, etc.)?

Have you ever taken any of the following medications: Fosamax (alendronate sodium), Boniva (ibandronate sodium), Actonel (risedronate sodium), Reclast (zoledronic acid), Zometa (zoledronic acid), Aredia (pamidronate disodium), Prolia (denosumab)? ☐ YES ☐ NO

If yes: Month/Year Started _____ Month/Year Stopped _____

ARE YOU ALLERGIC TO, OR HAVE YOU REACTED ADVERSELY TO (check or provide details of any not listed):

- | | | | |
|--|--------------------------------------|---------------------------------------|---|
| <input type="checkbox"/> Local anesthetic(s) | <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Latex | <input type="checkbox"/> Iodine/Shellfish |
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Amoxicillin | <input type="checkbox"/> Tetracycline | <input type="checkbox"/> Erythromycin <input type="checkbox"/> Other antibiotics |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Advil | <input type="checkbox"/> Aleve | <input type="checkbox"/> Other NSAIDS |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Morphine | <input type="checkbox"/> Demerol | <input type="checkbox"/> Other narcotic analgesics |
| <input type="checkbox"/> Versed | <input type="checkbox"/> Valium | <input type="checkbox"/> Scopolamine | <input type="checkbox"/> Barbiturates <input type="checkbox"/> Other sedatives/sleeping pills |

Do you or have you had any of the following:

- | | |
|--|--|
| Heart disease/heart attack/MI <input type="checkbox"/> YES <input type="checkbox"/> NO | Anemia <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Coronary bypass grafts <input type="checkbox"/> YES <input type="checkbox"/> NO | GERD/Acid Reflux/Hiatal Hernia <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Hypertension/high blood pressure <input type="checkbox"/> YES <input type="checkbox"/> NO | Pollen/food allergies <input type="checkbox"/> YES <input type="checkbox"/> NO |
| High cholesterol <input type="checkbox"/> YES <input type="checkbox"/> NO | Sinus trouble <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Congestive heart failure <input type="checkbox"/> YES <input type="checkbox"/> NO | Osteoarthritis <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Artificial heart valve <input type="checkbox"/> YES <input type="checkbox"/> NO | Osteoporosis/osteopenia <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Rheumatic fever <input type="checkbox"/> YES <input type="checkbox"/> NO | Asthma <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Bruise easily <input type="checkbox"/> YES <input type="checkbox"/> NO | Hepatitis/jaundice/liver disease <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Mitral valve prolapse or heart murmur <input type="checkbox"/> YES <input type="checkbox"/> NO | Tuberculosis <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Congenital heart condition <input type="checkbox"/> YES <input type="checkbox"/> NO | Substance addiction or alcoholism <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Artificial joint in place <input type="checkbox"/> YES <input type="checkbox"/> NO | Chemotherapy (any type) <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Bleeding disorder/hemophilia <input type="checkbox"/> YES <input type="checkbox"/> NO | Hemodialysis <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Stroke (CVA) or TIA's <input type="checkbox"/> YES <input type="checkbox"/> NO | Sleep apnea <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Emphysema/COPD <input type="checkbox"/> YES <input type="checkbox"/> NO | HIV/AIDS <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Diabetes (Type 1, insulin-dependent) <input type="checkbox"/> YES <input type="checkbox"/> NO | Depression/anxiety <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Diabetes (Type 2, no insulin) <input type="checkbox"/> YES <input type="checkbox"/> NO | Panic anxiety <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Kidney trouble <input type="checkbox"/> YES <input type="checkbox"/> NO | Persistent cough or cold <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Thyroid disease <input type="checkbox"/> YES <input type="checkbox"/> NO | Radiation treatment <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Seizure disorder <input type="checkbox"/> YES <input type="checkbox"/> NO | Rheumatoid arthritis <input type="checkbox"/> YES <input type="checkbox"/> NO |

Patient Name _____

Women Only

Are you pregnant (yes if not sure)? ☐ YES ☐ NO Do you anticipate becoming pregnant? ☐ YES ☐ NO
Are you nursing? ☐ YES ☐ NO Are you taking birth control pills? ☐ YES ☐ NO

Mountain Periodontics Dental History

How many times a day do you BRUSH your teeth? ☐ 1 ☐ 2 ☐ 3 ☐ occasionally ☐ after meals
Do you use an ELECTRIC toothbrush (if so, what brand)? ☐ YES _____ ☐ NO
Do you use a WaterPik or WaterFlosser (if so, what brand)? ☐ YES _____ ☐ NO
How many times a day do you FLOSS? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ occasionally ☐ after meals
How many times a day do you use TOOTHPLICKS? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ occasionally ☐ after meals
How many times a day do you use an INTERDENTAL or PROXABRUSH? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ occasionally ☐ after meals
How many times a day do you use SUPERFLOSS? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ occasionally ☐ after meals
How many times a day do you use RUBBER TIPS or STIMUDENTS? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ occasionally ☐ after meals
Do you use TOBACCO (including vaping) in any form (if so, what type and how often)? ☐ YES ☐ NO

If applicable, how long have you worn dentures? _____

Please check YES or NO to the following providing details as needed

Have you ever been given professional instructions on how to clean your teeth and gums? ☐ YES ☐ NO
Have you noticed any loosening of the teeth? ☐ YES ☐ NO
Has anyone in your family lost teeth because of periodontal disease or pyorrhea? ☐ YES ☐ NO
Are any of your teeth sensitive to hot or cold? If so, where? ☐ YES ☐ NO
Do your gums bleed? If so, where? ☐ YES ☐ NO
Are your gums sore, tender, spongy or red? If so, where? ☐ YES ☐ NO
Do any of your teeth hurt to bite on? If so, where? ☐ YES ☐ NO
Do you have a problem with food packing between your teeth? If so, where? ☐ YES ☐ NO
Do you often experience bad taste or odor in the mouth? ☐ YES ☐ NO
Do you grind or clench your teeth? ☐ YES ☐ NO Have you had braces (orthodontics)? ☐ YES ☐ NO
Do your jaw joints pop or click? ☐ YES ☐ NO Do you have difficulty speaking? ☐ YES ☐ NO
Do you have difficulty swallowing? ☐ YES ☐ NO Is there pain in your jaw joints? ☐ YES ☐ NO
Are you very nervous in the dental office? ☐ YES ☐ NO Have you ever fainted in the dental office? .. ☐ YES ☐ NO
Do you have difficulty chewing food? ☐ YES ☐ NO Do you gag easily? ☐ YES ☐ NO
Do you like the appearance of your teeth? ☐ YES ☐ NO
Do you avoid smiling because of your teeth or mouth? ☐ YES ☐ NO
Do you avoid going out in public because of your teeth or mouth? ☐ YES ☐ NO
Do you avoid certain types of foods due to dental disease or mouth comfort? ☐ YES ☐ NO
Do you think your teeth are affecting your health in any way? ☐ YES ☐ NO
Have you ever had a negative or traumatic experience in the dental office? ☐ YES ☐ NO
Have you ever had an injury to your face or jaws? ☐ YES ☐ NO
Are you pleased with your partial or denture (removable or bridge)? ☐ YES ☐ NO
Please provide any other comments you feel may be appropriate to your needs. _____

Responsibility and Consent Statement

If I have any change in health, I will inform the doctor at the beginning of my next visit.

Signature of Patient/Legal Guardian: _____ Date: _____

Signature of Doctor: _____ Date: _____

Mountain Periodontics P.C.
Gregg R. Codelli D.D.S.

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. (Posted on office wall)

(Signature)

(Date)

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgment 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)
-
-
-