Alec J. Temlock, DMD, MS, Inc.
San Francisco Periodontics and Implant Dentistry

Patient Information Questionnaire

Patient Information

Patient's Name: _____ Today's Date: _____

Social Security Number (Required): _____ Date of Birth: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Email Address: _____

Emergency Contact Information

Emergency Contact Name: _____ Phone: _____

Dental Insurance Information

Insurance Company Name: _____ Phone: _____

Member/Subscriber Identification Number: _____

Policy Holder: _____ Relationship: _____

Social Security Number (Required): _____ Date of Birth: _____

Employer: _____ Phone: _____

Financial, Insurance, and Cancellation Policy

Payment is expected at the time services are provided. We accept cash and most debit/credit cards. We also offer financing options through CareCredit. We are in-network for many insurance plans; however, your insurance policy is a contract between you, your employer, and your insurance company. We are not part of the insurance contract except to accept the insurance company's fees. As a courtesy, we will attempt to estimate your insurance payments and collect payments from your insurance company. The estimate is only an approximation, and you are ultimately responsible for any and all treatment fees regarding the services provided at this office. It is your responsibility to know your insurance contract's benefits and limitations.

Your treatment plan is individually tailored to your needs and is not based on your dental insurance benefits, coverage, or contract. Some procedures may not be covered by your insurance. We advise you to contact your insurance company directly for specific questions regarding your individual insurance contract, coverage, eligibility, benefits, limitations, authorizations, and payments. It is your responsibility to fully understand the coverage and limitations of your insurance policy. In the event that we do not receive payment from your insurance company within 90 days of filing a claim, the balance will be your responsibility. You are ultimately responsible for all fees associated with treatment regardless of your insurance benefits or coverage.

Failure to show for your appointment or failure to notify the office at least 48 hours in advance to cancel or change your appointment is subject to a $75 cancellation fee.

_____ _____

Patient or Guardian Signature Date

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Dental History Questionnaire

General Dentist Name: _____ Office Phone: _____

City: _____ State: _____

Last Dental Cleaning: _____ Dental Cleaning Frequency: _____

Oral Hygiene Routine

What is your normal oral hygiene routine at home? (Check all that apply)

☐ Electric Toothbrush ☐ Manual Toothbrush

How many times a day do you brush your teeth? _____

☐ Dental Floss ☐ Mouth Rinses ☐ Floss Threader ☐ StimuDent

☐ Proxy Brushes ☐Water-Pik ☐Rubber Tip ☐Toothpicks

☐ Other (please describe): _____

Adverse Dental Reactions (Check All That Apply):

☐ Dental Anxiety ☐ Dental Material Reaction or Allergy

☐ Difficulty Getting/Staying Anesthetized ☐ Strong Gauge Reflex

☐ Latex Allergy ☐ Lost Consciousness During Procedure

☐ Other (please describe): _____

Previous Periodontal Treatment (Check All That Apply):

☐ Scaling and Root Planing/Deep Cleanings ☐ Extractions

☐ Periodontal Surgery ☐ Bone Graft/Regeneration

☐ Soft Tissue Graft ☐ Implants

Other: _____

Dental History: (Please answer the following questions)

Y N

☐☐ Are you currently experiencing any pain in your mouth, head, or neck?

☐☐ Do you experience any sensitivity in your teeth, gums, or mouth?

☐☐ Do you experience any bleeding when you brush, floss, or use other oral cleaning devices?

☐☐ Are you aware of any dental treatment planned but yet not completed by your general dentist?

☐☐ Have you ever been told you clench or grind your teeth?

☐☐ Has any dentist ever recommended a protective guard for your teeth?

☐☐ Do you have any trouble chewing or swallowing?

☐☐ Have you ever been treated for tempromandibular dysfunction (TMD, TMJ)?

☐☐ Have you ever had a biopsy anywhere in your mouth?

☐☐ Have you previously been told to take antibiotics before dental treatment?

☐☐ Have you experienced any complications following any dental treatment?

☐☐ Have you been treated for any oral abnormality, disease, or pathology not already described?

If yes, please explain: _____

To the best of my knowledge, I answered every question completely and accurately. If I ever experience any changes in my oral health, I will inform Dr. Temlock immediately.

Patient's or Guardian's Signature: _____ Date: _____

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Medical and Health History Questionnaire

Primary Medical Physician Name: _____ Office Phone: _____

City: _____ State: _____

Date of Last Physical or Medical Exam: _____

Have you ever been treated for any of the following?

Y N	Y N	Y N
☐☐ Anemia	☐☐ Glaucoma	☐☐ Radiation or Chemotherapy
☐☐ Arthritis	☐☐ Head Injuries	☐☐ Respiratory Problems
☐☐ Artificial Joints	☐☐ Heart Murmur	☐☐ Rheumatic Fever
☐☐ Auto-Immune Disorders	☐☐ Hepatitis	☐☐ Rheumatism
☐☐ Blood Disease	☐☐ High Blood Pressure	☐☐ Sinus Problems
☐☐ Cancer	☐☐ High Cholesterol	☐☐ Stomach Problems
☐☐ Cardiovascular Disorders	☐☐ Kidney Disease	☐☐ Stroke
☐☐ Diabetes	☐☐ Liver Disease	☐☐ Tuberculosis
☐☐ Dizziness	☐☐ Mental Disorders	☐☐ Tumors
☐☐ Epilepsy	☐☐ Nervous Disorders	**Women Only**
☐☐Excessive Bleeding	☐☐ Pacemakers	☐☐Breast-Feeding
☐☐ Fainting	☐☐ Pulmonary Disorders	☐☐ Pregnant

Have you ever been treated for any other medical condition not described above? ☐Yes ☐No

If yes, please explain: _____

Do you have any health problems that need further clarification? ☐ Yes ☐ No

If yes, please explain: _____

Have you been admitted to a hospital or needed emergency care during the last two years?

☐Yes ☐No If yes, please explain: _____

Medications and Allergies

What prescription and over-the-counter medications do you currently take (please list all)?

_____

_____

Are you allergic to any medications or any other substances? ☐Yes ☐No

If yes, please list all allergies: _____

Social History

Do you have a history or currently use or consume any of the following?

Y N *(If yes, please describe your consumption frequency)*

☐☐ Alcohol: _____

☐☐ Tobacco (any form including smokeless tobacco or vaporizers): _____

☐☐ Recreational drugs: _____

To the best of my knowledge, I have answered every question completely and accurately. If I ever experience any changes in my health and medications, I will inform Dr. Temlock immediately.

Patient's or Guardian's Name (Printed): _____

Patient or Guardian Signature: _____ Date: _____