



JOHN E. RUTLEDGE, DDS, MS  
 Diplomate of American Board of Periodontology  
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 Diplomate of American Board of Periodontology  
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 Diplomate of American Board of Periodontology  
 PAULA C. SCHLEMMER, DMD, MS

Patient First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Telephone: Best number to reach you: \_\_\_\_\_ Alternative Number(s): \_\_\_\_\_

E-mail: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_ Age: \_\_\_\_\_

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

Students: School of Attendance: \_\_\_\_\_

Marital Status: (circle) Single Divorced Widowed Married: Spouse's Name: \_\_\_\_\_

Other Emergency Contact Name/Telephone: \_\_\_\_\_

Parent(s) Name (if patient is a minor, under 19): \_\_\_\_\_

Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

General Dentist: \_\_\_\_\_

Other Referring Dentist: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Telephone: \_\_\_\_\_

Preferred Pharmacy: \_\_\_\_\_ Telephone: \_\_\_\_\_

**BILLING//RESPONSIBLE PARTY INFORMATION**

Name: \_\_\_\_\_

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

Telephone: \_\_\_\_\_

Do you have dental insurance? \_\_\_\_\_ Primary Insurance Carrier: \_\_\_\_\_

Secondary Insurance Carrier: \_\_\_\_\_

*To the best of my knowledge, all of the preceding answers are true and correct. I understand that I am financially responsible for all dental services provided by Periodontal Offices, PC, regardless of dental insurance coverage, which is a contract between the insurance company and the employee. I also authorize the release of my records or dental information, as may be required.*

**\*\*Patient/Responsible Party Please Sign\*\***

**Date**

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

**PREMEDICATIONS**

- Y N Organ Transplant
- Y N Artificial Heart Valve
- Y N Artificial Joints

**CARDIOVASCULAR SYSTEM**

- Y N Angina Pectoris-Chest Pain
- Y N Congenital Heart Defect
- Y N Mitral Valve Prolapse
- Y N Pacemaker
- Y N Rheumatic Heart Disease/Fever
- Y N Stroke/Blood Clots
- Y N Heart Attack/Heart Surgery
- Y N High Blood Pressure
- Y N Low Blood Pressure
- Y N History of Endocarditis

**BLOOD - LYMPHATICS**

- Y N Anemia
- Y N Blood Disorders
- Y N Abnormal Bleeding
- Y N Blood Transfusion

**RESPIRATORY SYSTEM**

- Y N Asthma/Emphysema
- Y N COPD
- Y N Tuberculosis
- Y N Sinus Problems
- Y N Seasonal Allergies

**NERVOUS SYSTEM**

- Y N Seizures
- Y N Epilepsy
- Y N Neuritis/Neuralgia/Numbness
- Y N Depression

**BONES and JOINTS**

- Y N Osteo/Rheumatoid Arthritis
- Y N Back, Neck, Jaw Injury

**ENDOCRINE SYSTEM**

- Y N Diabetes
- Y N Thyroid Problems

**GENITOURINARY/GASTROINTESTINAL**

- Y N Kidney Disease
- Y N Stomach/Intestinal Problems
- Y N Liver Disease
- Y N Jaundice
- Y N Ulcers, Reflux Disease
- Y N Eating Disorders

**INFECTIOUS DISEASES**

- Y N Hepatitis (A,B,C, or other)
- Y N AIDS, ARC, HIV, ANTI-HIV
- Y N Venereal Disease
- Y N Cold Sores

**GENERAL**

- Y N Cancer-Chemotherapy
- Y N Radiation Therapy
- Y N History of Bisphosphonate Use
- Y N Deafness
- Y N Eye Problems- Glaucoma
- Y N Alcohol abuse
- Y N Drug Abuse

**SMOKING/TOBACCO USE**

- Y N Do you smoke/use tobacco  
Packs/Day/Year \_\_\_\_\_

**WOMEN**

- Y N Are you pregnant
- Y N Using Birth Control
- Y N Are you nursing

**ALLERGY: Are you allergic/had a reaction to:**

- Y N Aspirin
- Y N Codeine
- Y N Dental Anesthetic
- Y N Erythromycin
- Y N Jewelry
- Y N Latex
- Y N Metals
- Y N Penicillin
- Y N Tetracycline
- Y N Others \_\_\_\_\_

**Please list your medications (Rx, Herbal,OTC):**

- 1) \_\_\_\_\_ 5) \_\_\_\_\_
- 2) \_\_\_\_\_ 6) \_\_\_\_\_
- 3) \_\_\_\_\_ 7) \_\_\_\_\_
- 4) \_\_\_\_\_ 8) \_\_\_\_\_

**Hospitalizations:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Other conditions, otherwise not listed:**

\_\_\_\_\_

\_\_\_\_\_

Signature of Patient, Parent/Guardian \_\_\_\_\_

Date \_\_\_\_\_



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**Consent for Use and Disclosure of Health Information**

**Patient Name Giving Consent:** \_\_\_\_\_

**Purpose of Consent:** By signing this form you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

**Notice of Privacy Practices:** You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information and of other important matters about your protected health information. A copy of our Privacy Practices is available upon request.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

**Right to Revoke:** You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to Pioneer Periodontics & Implant Dentistry, PC, Diane Harris, contact person. Please understand that revocation of the Consent will not affect any action we took in reliance on this Consent before we received your revocation. We may decline to treat you or to continue treating you if you revoke this Consent.

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

\_\_\_\_\_  
**\*\*Signature of Patient/Responsible Party\*\***

\_\_\_\_\_  
 Date

**If this Consent is signed by a Parent, Guardian, or Personal Representative (PR) on behalf of the patient, complete the following:**

Parent, Guardian or PR's name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Date: \_\_\_\_\_

.....  
**Revocation of Consent-Sign only if Patient wishes to revoke their Consent**

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

\_\_\_\_\_  
**\*\*Signature of Patient/Responsible Party\*\***

\_\_\_\_\_  
 Date