Welcome to Dr. Frankle's Office

Please print all informaton

Name____________________ Birth date__________ Marital Status_____________

Address__________________________ City__________________ Zip__________

Home Phone ______________________ Cell Phone___________________________

Employer______________________________ Occupation_____________________

Business Address_______________________ City_______________ Zip__________

Work Phone______________________ Patient Referred By_____________________

Reason for Visit________________________Dental Insurance__________________

Height_________ Weight___________ Date of last Physical Exam_______________

In Case of Emergency Contact_______________________ Phone_________________

Since the cause of periodontal disease is a combination of many factors and often very complex, it is necessary to root out any possible causative factor. The success of treatment depends upon this. Although many of these questions may seem to have nothing to do with your gum condition, they are all related to possible contributing factors.

Present Health

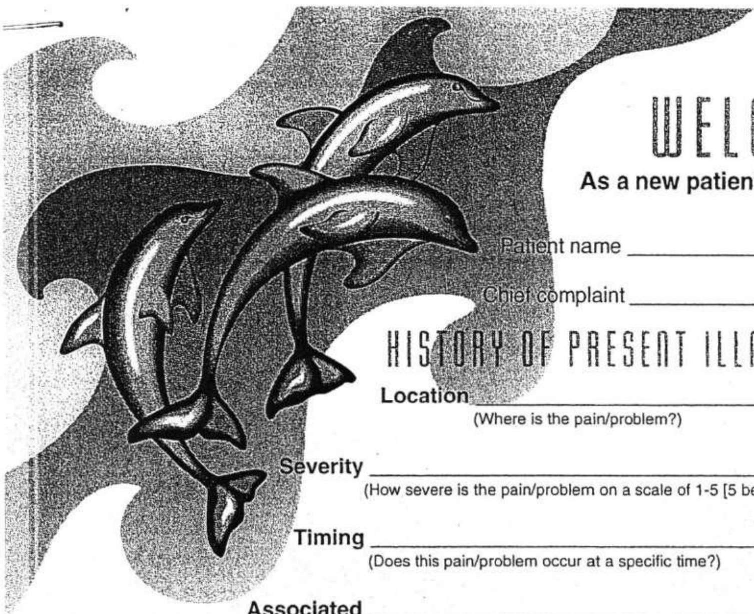
1. Do you consider yourself to be in good health?............ Y N DK 1.
2. Are you presently under a physician's care?............ Y N DK 2.
3. Are you taking any medication? .... Y N DK 3.

Past Illnesses and Operations

4. Have you ever had any major operations?............ Y N DK 4.
5. Have you ever been seriously ill?............ Y N DK 5.
6. Have you ever been hospitalized?............ Y N DK 6.

Cardiovascular

7. Has a doctor ever said you have heart trouble?............ Y N DK 7.
8. Do you get out of breath easily?............ Y N DK 8.
9. Has a doctor ever said your blood pressure is too high or too low?............ Y N DK 9.
10. As a child, did you have Rheumatic fever, growing pains, or............ Y N DK 10.
    twitching of the limbs?
11. Do you often have fainting spells?............ Y N DK 11.
12. Have you ever had Rheumatic heart disease or Saint Vitus' dance?............ Y N DK 12.
13. Are your ankles often badly swollen?............ Y N DK 13.
14. Have you ever had severe nose bleeds?............ Y N DK 14.
15. Do you sleep with more than one pillow?............ Y N DK 15.



WELCOME TO OUR PRACTICE

As a new patient, please fill out the information found below to the best of your ability.

Patient name ______________________ Age __________ Date __________

Chief complaint ______________________

HISTORY OF PRESENT ILLNESS

Location ______________________
(Where is the pain/problem?)

Duration ______________________
(How long have you had this pain/problem, or when did it start?)

Severity ______________________
(How severe is the pain/problem on a scale of 1-5 [5 being the most severe])

Context ______________________
(Where were you at the onset of this pain/problem?)

Timing ______________________
(Does this pain/problem occur at a specific time?)

Quality ______________________
(Example: normal versus abnormal color, activity, etc.)

Associated Signs/ Symptoms ______________________
(What other associated problems have you been having?)

Modifying Factors ______________________
(What makes the pain/problem worse or better? Have you had previous episodes?)

PATIENT MEDICAL HISTORY

Have you ever had the following (check "no" or "yes", leave blank if uncertain):

Measles	☐ No ☐ Yes	Anemia	☐ No ☐ Yes	Blood or Plasma Transfusions	☐ No ☐ Yes	Bronchitis	☐ No ☐ Yes
Mumps	☐ No ☐ Yes	Bladder Infections	☐ No ☐ Yes	Back Trouble	☐ No ☐ Yes	Mitral Valve Prolapse	☐ No ☐ Yes
Chickenpox	☐ No ☐ Yes	Epilepsy	☐ No ☐ Yes	High or Low Blood Pressure	☐ No ☐ Yes	Stroke	☐ No ☐ Yes
Whooping Cough	☐ No ☐ Yes	Migraine Headaches	☐ No ☐ Yes	Hemorrhoids	☐ No ☐ Yes	Hepatitis	☐ No ☐ Yes
Scarlet Fever	☐ No ☐ Yes	Tuberculosis	☐ No ☐ Yes	Asthma	☐ No ☐ Yes	Ulcer	☐ No ☐ Yes
Diphtheria	☐ No ☐ Yes	Diabetes	☐ No ☐ Yes	Hives or Eczema	☐ No ☐ Yes	Kidney Disease	☐ No ☐ Yes
Smallpox	☐ No ☐ Yes	Cancer	☐ No ☐ Yes	AIDS or HIV+	☐ No ☐ Yes	Thyroid Disease	☐ No ☐ Yes
Pneumonia	☐ No ☐ Yes	Polio	☐ No ☐ Yes	Infectious Mono	☐ No ☐ Yes	Bleeding Tendency	☐ No ☐ Yes
Rheumatic Fever	☐ No ☐ Yes	Glaucoma	☐ No ☐ Yes	High Cholesterol	☐ No ☐ Yes	Any Other Disease (please list) ________	☐ No ☐ Yes
Heart Disease	☐ No ☐ Yes	Hernia	☐ No ☐ Yes	Usual Weight	________		
Arthritis	☐ No ☐ Yes						

Previous Hospitalizations/Surgeries/Serious Illnesses	When	Hospital, city, state

Medications: Include strength and daily dose ______________________ ☐ None

Include non-prescription: Ex; Aspirin, Vitamins, Fen-Phen, Herbals, L-Triptophan ______________________ ☐ None

Habits

Smoking: Type and amount per day. ______________________ ☐ None

If former smoker: Type, amount and date quit. ______________________ ☐ None

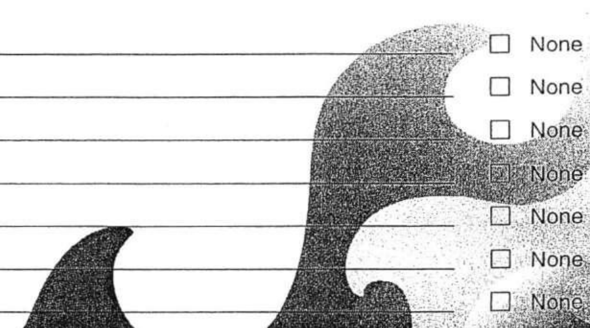
Alcohol: Type and amount per day. ______________________ ☐ None

If former user: Type, amount and date quit. ______________________ ☐ None

Caffeine use: Type and amount per day. Ex; coffee, tea, soda drinks ______________________ ☐ None

Herbal teas: Type and amount ______________________ ☐ None

Recreation drugs: ______________________ ☐ None



THE BETHESDA
TEMPOROMANDIBULAR JOINTAND IMPLANT CENTER

FINANCIAL POLICY

Because medical and dental insurance companies have become increasingly difficult to work with, we have been forced to establish a policy which does not place us in a constant confrontational role or force us to compromise the quality of care to our patients.

When your office visit is completed, the receptionist will provide you with a super bill to submit to your insurance company so that you can be reimbursed. A dental claim will be submitted to your dental insurance company for reimbursement as well.

We will answer any questions your insurance company may raise about diagnosis or treatment in an appropriate, timely manner, but it is important to understand that the legal contract is between you and your insurance company—we are not part of the relationship. We are unable to "force" an insurance company to fulfill its obligations to you. Please contact your insurance company to find out if a procedure will be covered under your particular policy.

Failure to continue treatment after lab work has been completed will result in a charge equal to ½ of the usual charge for the completed lab work.

We would appreciate your payment for services as you receive them. **Please note that all accounts with a balance after 30 days are subject to a <u>finance charge of 1% per month.</u>**

I understand that I am directly and personally responsible to BTMJFPTC for all bills and that this authorization is made solely for the additional protection of BTMJFPTC. I agree to be responsible for all expenses, including interest at 1% per month (12% per year), reasonable attorney fees and court costs incurred by BTMJFPTC in collection of monies due and owing by me. I also agree to waive the defense of the statute of limitations as it pertains to any claim filed against me beyond three years (or other statutory period) after services are rendered.

<u>Attention Medicare Patients</u>: We will no longer submit claims to Medicare due to the Opt Out contract. You will be expected to pay in full for all treatment at the time of service.

Please keep your appointments! Contact the office if you need to reschedule your appointment so that others can use the time. **<u>Failure to cancel your appointment without 24 hours notice will result in the usual charge.</u>**

I have read, understand and accept the above financial policy. I acknowledge that I am ultimately responsible for the amounts due and owing under this agreement regardless of my representation or coverage.

______________________ ______________ ______________________

Patient **Date** **Witness**