ph 916.786.7070
fx 916.786.5696

Jennifer Goss DDS
PERIODONTICS

125 Ascot Dr Ste. A
Roseville Ca 95661

PATIENT INFORMATION

Name _____

Date _____ SSN/HIC/Patient ID _____

Address _____

City _____ State _____ Zip _____

Home (_____) _____ - _____ Cell (_____) _____ - _____

Work (_____) _____ - _____ Ext (_____)

E-Mail _____

Sex ☐ M ☐ F Birth date _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Occupation _____ Employer _____

Guardian / Emergency Contact: _____ Phone Number _____

Who may we thank for your referral _____

Dental Insurance

Who is responsible for this account _____

Relationship to patient _____

Insurance Co. _____ ID # _____ Group # _____

Subscriber Name _____ Birth date _____ SS# _____

Do you have additional (secondary) insurance coverage? ☐ Yes ☐ No

Insurance Co. _____ ID # _____ Group # _____

Subscriber Name _____ Birth date _____ SS# _____

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. Jennifer Goss (Goss Periodontics) all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Name of Insurance Company(ies)

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payments for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or on year from the date signed below.

_____ _____ _____

Signature of Patient, Parent, Guardian or Representative | Print name of Patient, Parent, Guardian or Representative | Date

Consent for Use and Disclosure of Health Information

I have had full opportunity to read and consider 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, Parent, Guardian or Representative | Print name of Patient, Parent, Guardian or Representative | Date

Dental & Health History

Reason for today's visit_____

_____

Date of last Dental Exam _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad breath	○ Yes	○ No	Chew on one side of mouth	○ Yes	○ No	Mouth breathing	○ Yes	○ No
Bleeding gums	○ Yes	○ No	Cigarette, pipe, or cigar smoking	○ Yes	○ No	Mouth pain, brushing	○ Yes	○ No
Blisters on lips or mouth	○ Yes	○ No	Clicking or popping jaw	○ Yes	○ No	Orthodontic treatment	○ Yes	○ No
Burning sensation on tongue	○ Yes	○ No	Dry mouth	○ Yes	○ No	Pain around ear	○ Yes	○ No
			Food collection between the teeth	○ Yes	○ No	Periodontal treatment	○ Yes	○ No
			Grinding teeth	○ Yes	○ No	Sensitivity to cold	○ Yes	○ No
			Gums swollen or tender	○ Yes	○ No	Sensitivity to heat	○ Yes	○ No
			Jaw pain or tender	○ Yes	○ No	Sensitivity to sweets	○ Yes	○ No
			Lip or cheek biting	○ Yes	○ No	Sensitivity when biting	○ Yes	○ No
			Loose teeth or broken fillings	○ Yes	○ No	Sores or growths in your mouth	○ Yes	○ No

How often do you brush? _____

How often do you floss? _____

Physician's Name _____ Date of last visit _____

Have you ever taken the group of drugs referred to as "bisphophonates"? Such as Fosamax, Actonel or IV or injectable such as Zometa? ○ Yes ○ No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	○ Yes	○ No	Cortisone Treatments	○ Yes	○ No	Psychiatric Care	○ Yes	○ No
Anemia	○ Yes	○ No	Diabetes	○ Yes	○ No	Radiation Treatment	○ Yes	○ No
Arthritis, Rheumatism	○ Yes	○ No	Emphysema	○ Yes	○ No	Respiratory Disease	○ Yes	○ No
Artificial Heart Valves	○ Yes	○ No	Epilepsy	○ Yes	○ No	Rheumatic Fever	○ Yes	○ No
Artificial Joints	○ Yes	○ No	Fainting or dizziness	○ Yes	○ No	Scarlet Fever	○ Yes	○ No
Asthma	○ Yes	○ No	Glaucoma	○ Yes	○ No	Shortness of Breath	○ Yes	○ No
Back Problems	○ Yes	○ No	Headaches	○ Yes	○ No	Sinus Trouble	○ Yes	○ No
Bleeding abnormally with extractions or surgery	○ Yes	○ No	Heart murmur	○ Yes	○ No	Special Diet	○ Yes	○ No
Blood Disease	○ Yes	○ No	Heart problems	○ Yes	○ No	Stroke	○ Yes	○ No
Cancer	○ Yes	○ No	Hepatitis Type _____	○ Yes	○ No	Swollen Feet or Ankles	○ Yes	○ No
Chemical Dependency	○ Yes	○ No	Herpes	○ Yes	○ No	Swollen Neck Glands	○ Yes	○ No
Chemotherapy	○ Yes	○ No	High Blood Pressure	○ Yes	○ No	Thyroid Problems	○ Yes	○ No
Circulatory Problems	○ Yes	○ No	Jaundice	○ Yes	○ No	Tonsillitis	○ Yes	○ No
Congenital Heart Lesions	○ Yes	○ No	Jaw Pain	○ Yes	○ No	Tuberculosis	○ Yes	○ No
Cough, persistent or bloody	○ Yes	○ No	Kidney Disease	○ Yes	○ No	Tumor or growth on head or neck	○ Yes	○ No
			Liver Disease	○ Yes	○ No	Ulcer	○ Yes	○ No
			Low Blood Pressure	○ Yes	○ No	Venereal Disease	○ Yes	○ No
			Mitral Valve Prolapse	○ Yes	○ No	Weight Loss, Unexplained	○ Yes	○ No
			Nervous Problems	○ Yes	○ No			
			Pacemaker	○ Yes	○ No			

Women:

Are you pregnant? ○ Yes ○ No

Due date _____

Are you nursing? ○ Yes ○ No

Taking birth control ○ Yes ○ No

Medications

List any medications you are currently taking

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Allergies

☐ Aspirin
☐ Barbiturates (sleeping pills)
☐ Codeine
☐ Iodine
☐ Latex
☐ Local Anesthetic
☐ Penicillin
☐ Sulfa

Other drug allergies: _____

_____

Reviewed by: _____

Reset form