Elite
Periodontics & Implants

Name _____ Cell Phone _____ Email _____
Address _____ City _____ Zip _____ Home Phone _____
Birth Date _____ Marital Status _____
Patient Employed By _____ Business Address _____
Occupation _____ Business Phone _____
Name of Spouse _____ Spouse Employed By _____
Business Address _____ Business Phone _____
Occupation _____
Name of Dentist _____ Address _____ City _____
Name of Physician _____ Address _____ City _____
Patient Referred By _____ Reason For This Visit _____
Name of Your Dental Insurance Company _____ S.S. # _____
Name of Person Responsible For Payment _____
Address _____ Phone H _____ W _____

HEALTH HISTORY

Are you in good health? ____Y ____N
Are you now under the care of a physician? ____Y ____N
Are you taking any drug or medicine (including birth control pills, aspirin)? ____Y ____N
Have you had excessive bleeding requiring special treatment? ____Y ____N
Have you ever been in the hospital or had surgery? ____Y ____N
Have you had periodontal therapy? ____Y ____N
Have you had orthodontic therapy? ____Y ____N
Do you clench or grind your teeth? ____Y ____N
Women: Are you pregnant? ____Y ____N

Are you allergic to or have you reacted adversely to:

Local Anesthetics (Novocaine)? _____ ____Y ____N
Penicillin or other Antibiotics? _____ ____Y ____N
Barbituates, Sedatives, Sleeping Pills? _____ ____Y ____N
Sulfa Drugs? _____ ____Y ____N
Aspirin? _____ ____Y ____N
Other Drugs? _____ ____Y ____N

Have you ever had or do you now have any conditions listed?

Radiation therapy	____Y ____N	Blood in sputum	____Y ____N	Ulcers	____Y ____N
Lack or loss of body hair	____Y ____N	Wheezing, asthma	____Y ____N	Hoarseness	____Y ____N
Bone deformity, fracture	____Y ____N	Venereal disease	____Y ____N	Cough	____Y ____N
Tuberculosis, exposure to	____Y ____N	Thyroid trouble	____Y ____N	Jaundice	____Y ____N
Heart murmur	____Y ____N	Shortness of breath	____Y ____N	Hepatitis	____Y ____N
Heart attack, surgery	____Y ____N	Pigmentations	____Y ____N	Diabetes	____Y ____N
Difficulty in swallowing	____Y ____N	Prosthetic joints	____Y ____N	Anemia	____Y ____N
Difficulty, pain on urination	____Y ____N	Double vision	____Y ____N	Leukemia	____Y ____N
High, low blood pressure	____Y ____N	Hearing loss	____Y ____N	Sinusitis	____Y ____N
Rheumatic, scarlet fever	____Y ____N	Excessive thirst	____Y ____N	Earache	____Y ____N
Pain, pressure in chest	____Y ____N	Drooping of eyelid	____Y ____N	Glaucoma	____Y ____N
Swollen, painful joints	____Y ____N	Frequent nosebleeds	____Y ____N	AIDS	____Y ____N
Frequent sore throat	____Y ____N	Blurring of vision	____Y ____N	Cancer	____Y ____N
Muscle weakness, pain	____Y ____N	Blood in urine	____Y ____N	Itching, Rash	____Y ____N
Abdominal pain, ulcers	____Y ____N	Weight change	____Y ____N	Do you smoke?	____Y ____N
Depression, excessive worry	____Y ____N	Frequent headaches	____Y ____N	Easy Bruising	____Y ____N
Parasthesias, numbness	____Y ____N	Nervous breakdown	____Y ____N	Mitral Valve Prolapse	____Y ____N
Dizziness, fainting	____Y ____N	Blood transfusion	____Y ____N		
Excessive urination	____Y ____N	Swelling of ankles	____Y ____N		

So that we may maintain the operation of our office on sound principles and to assure you and other patients of uninterrupted treatment, it is necessary for all patients to accept and adhere to a definite arrangement of appointments and fees. Once you have made an appointment, remember this time is reserved for you-therefore: AT LEAST 24 HOURS NOTICE MUST BE GIVEN IF CANCELLATION IS ABSOLUTELY NECESSARY. OTHERWISE A CHARGE OF THE USUAL FEE FOR THE SERVICE TO HAVE BEEN RENDERED WILL BE MADE.

Date _____ Signature _____

Reviewed By _____