PERIODONTICS & IMPLANT DENTISTRY, P.A.

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 _____