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Diplomate of the American Board of Periodontology
Practice limited to Periodontics
Services in Dental Implants

PATIENT INFORMATION

Patient's Name:_____
Last First Middle

Preferred Name:_____ Date of Birth:_____

Marital Status:_____ Social Security #:_____

Address:_____
Street City Zip

E-Mail:_____ Home Phone:_____

Work Phone:_____Extension:_____

Mobile:_____

Who referred you to our office? _____

Employer:_____Occupation:_____

Insurance Company:_____I.D. #:_____

Insured Party:_____Date of Birth:_____

Secondary Insurance Company:_____I.D. #:_____

Insured Party:_____Date of Birth:_____

Spouse's Name:_____Date of Birth:_____

Spouse's Social Securtiy #:_____Phone:_____

Spouse's Employer:_____Occupation:_____

DENTAL HISTORY

Yes No
( ) ( ) Are you in pain at this time?

( ) ( ) Are you able to bite and chew as well as you like?

( ) ( ) Are you happy with your smile?

What are your goals for your teeth?_____

_____

Yes No
( ) ( ) Do you use a toothbrush with a timer?

When is the last time you had your teeth cleaned?_____

How often do you get your teeth cleaned?_____

MEDICAL HISTORY

Height_____Weight_____Age:_____

Please list all medications that you are taking:_____

_____

_____

Have you ever had:

Yes	No		Yes	No	
( )	( )	Prosthetic heart valve or other heart prosthesis	( )	( )	Congenital Heart Disease
			( )	( )	Heart Attack
( )	( )	Infective endocarditis	( )	( )	Chest pains on exertion
( )	( )	Other Heart Problems			

If yes, please explain:_____

Have you ever taken medication for osteoporosis or osteopenia? Yes ( ) No ( )

Name of medication(s):_____

Do you have any joint replacements? Yes ( ) No ( )

Do you have allergies to any medications? Yes ( ) No ( )
Name of medication(s):_____

Are you allergic to latex? Yes ( ) No ( )

Have you ever had excessive bleeding with cuts or extractions? Yes ( ) No ( )

Do you smoke? Yes ( ) No ( )
Do you chew tobacco? Yes ( ) No ( )

Have you ever had radiation treatment to the head and neck? Yes ( ) No ( )

Have you ever had a blood transfusion? Yes ( ) No ( )

Have you ever been hospitalized? Yes ( ) No ( ) For what?_____

Have you ever had surgery? Yes ( ) No ( ) Procedure:_____

Did you have bleeding problems after surgery? Yes ( ) No ( )

What is the name of your physician?_____
When is the last time you saw your physician?_____

Has a Doctor ever told you that you have any of the following?

( ) High Blood Pressure	( ) HIV	( ) Tuberculosis
( ) High Cholesterol	( ) Hepatitis	( ) Epilepsy
( ) Diabetes	( ) Osteoporosis	( ) Anemia
( ) Arthritis	( ) GERD/Ulcers	( ) Kidney problems
( ) Asthma	( ) Stroke	( ) Thyroid Problems
( ) Glaucoma	( ) Cancer	( ) Sleep Apnea

Have you had any other disease or condition I should know about? Yes ( ) No ( )

Please explain:_____

(Women) Are you pregnant? Yes ( ) No ( ) Don't know ( )

To the best of my knowledge, the above questions are answered completely and accurately.

Patient signature:_____Date:_____