PERIODONTAL SPECIALISTS

PRACTICE LIMITED TO PERIODONTICS Date_____

Name _____
(if minor, patient name)

Residence Street _____

City_____ State _____ Zip _____

Residence Phone Area Code (_____) _____

Cell Phone Area Code (_____) _____

Email Address _____

Place of Employment _____

Occupation _____

Business Address _____

Business Phone Area Code (_____) _____

Marital Status _____

Social Security No. (patient)_____

If Minor - Responsible Party _____

Address_____

Dental Insurance Co. _____

Policy Holder_____

If other than patient please provide:

Place of Employment:_____

Social Security No: _____

Date of Birth: _____

Closest relative to contact in case of emergency_____

Relationship _____ Phone (_____) _____

Referred by: _____

1. How would you describe your general health? ☐ poor ☐ fair ☐ good
   Date of last medical exam?_____
2. Are you currently under the care of a medical doctor? _____ ☐ yes ☐ no
3. Do you consume alcohol? _____ ☐ yes ☐ no
   How many drinks per weeks? _____
4. Do you use any non-prescription mood-altering drugs? _____ ☐ yes ☐ no
5. Have you ever had an unusual reaction to
   dental anesthesia (gas or 'shots')?_____ ☐ yes ☐ no
   If 'yes,' more than once? _____ ☐ yes ☐ no
   Date of last occurence? _____
   Month/Year
6. Following injuries or professional dental treatment, have
   you had bleeding problems?_____ ☐ yes ☐ no
7. Is there a history of diabetes in your family?_____ ☐ yes ☐ no
8. Have you recently lost
   weight unintentionally (with good appetite)? _____ ☐ yes ☐ no
9. Have you ever smoked?_____ ☐ yes ☐ no
10. Do you smoke now? _____ ☐ yes ☐ no
    If so, how much a day? _____
11. Do you use or have you ever used any
    chewing tobacco? _____ ☐ yes ☐ no
12. Do injuries or cuts take longer to
    heal now than they did previously? _____ ☐ yes ☐ no
13. Does your mouth feel dry or do you have
    a burning sensation of lip or tongue?_____ ☐ yes ☐ no
14. Have you taken or been given injections
    of steroids such as cortisone? _____ ☐ yes ☐ no
15. Are you on a prescribed diet?_____ ☐ yes ☐ no
16. Have you ever been told to take antibiotics
    before dental appointments?_____ ☐ yes ☐ no

Indicate yes or no to the following questions.

Have you become sick from, shown an allergy to, or been told *not* to take:

YES	NO	
☐	☐	Penicillin
☐	☐	Other antibiotics
☐	☐	Codeine
☐	☐	Novocaine or other dental anesthetics
☐	☐	Latex
☐	☐	Other drugs or medicines _____

List current medications and dosages (including anticoagulants, Aspirin, birth control pills, vitamins, herbal meds):

_____

_____

_____

_____

_____

Have you ever had any of the following:

YES	NO	
☐	☐	Heart disease
☐	☐	Heart murmur
☐	☐	High blood pressure
☐	☐	Shortness of breath w/o exercise or when lying down
☐	☐	Pain, pressure, or tight feeling in chest
☐	☐	Heart attack
☐	☐	Rheumatic fever
☐	☐	Artificial joints, heart valve, or prosthesis
☐	☐	Mitral valve prolapse
☐	☐	Blood transfusions
☐	☐	Blood trouble, anemia, leukemia
☐	☐	Ulcer history
☐	☐	AIDS or AIDS exposure
☐	☐	Lung trouble (TB, asthma, emphysema)
☐	☐	Fainting spells, convulsions, epilepsy
☐	☐	Hepatitis, liver disease, jaundice
☐	☐	Splenectomy
☐	☐	Diabetes
☐	☐	Osteoporosis
☐	☐	Treatment for chemical dependency
☐	☐	Nervous breakdown, psychotherapy
☐	☐	Recurrent cold sores
☐	☐	Radiation/chemotherapy
☐	☐	Other medical conditions
		_____
☐	☐	Currently pregnant or breast feeding
☐	☐	Hospitalization
☐	☐	Surgery_____ (please list)
		_____
		_____

Height _____ **Weight** _____

I authorize release of my records as deemed necessary.

Signature_____

Date of birth_____

Physician's name _____

Physician's address _____

Reviewed by _____