PERIODONTAL SPECIALISTS

PRACTICE LIMITED TO PERIODONTAL & IMPLANT THERAPY

Name _____ Date _____
(if minor, patient's name)
Home Address _____
City _____ State _____ Zip _____
Home Phone (_____) _____ Cell Phone (_____)_____
Email Address _____
Date of Birth _____
Place of Employment/Occupation _____
Work Phone (_____)_____
Marital Status _____Social Security No _____
If Guardian/Caretaker - Name_____
Address _____
Dental Insurance Co _____
Policy Holder _____
If policy holder is someone other than pt, please provide:
Place of Employment _____
Social Security Number _____
Date of Birth _____
In Case of Emergency Contact _____
Relationship _____ Phone (_____)_____

1. How would you describe your general health? □ Poor □ Fair □ Good
2. **Are you currently under the care of a medical doctor?** □ Yes □ No
   Physician's Name: _____
   Physician's Address _____
   Date & Reason for Last Visit _____
3. Do you consume alcohol? □ Yes □ No How many drinks per week? _____
4. Do you use any non-prescription drugs or illicit substances? □ Yes □ No
5. Do you currently smoke cigarettes, cigars, or vape? □ Yes □ No
   If so, please circle which one above. How much per day?_____
   Do you have any interest in quitting at this time? □ Yes □ No
6. If you used to smoke, how long ago did you quit? _____
7. Do you currently use chewing tobacco? □ Yes How much? _____ □ No
8. Have you ever had an unusual reaction to dental novocaine? □ Yes □ No
   If yes, what happened and when? _____
9. After dental treatment, have you had bleeding problems? □ Yes □ No
10. Is there a history of diabetes in your family? _____ □ Yes □ No
11. Are you on a prescribed diet? □ Yes □ No
12. Have you recently lost weight unintentionally? □ Yes □ No
13. Do injuries or cuts take longer to heal for you? □ Yes □ No
14. Do you have any rashes or lesions show up
    on your skin or in your mouth?_____ □ Yes □ No
15. Does your mouth ever feel dry? □ Yes □ No
16. Do you get a burning sensation on your lips or tongue? □ Yes □ No
17. In the last 24 months, have you been prescribed steroids? □ Yes □ No
    If yes, dosage and when: _____
18. Have you been told to take antibiotics before dental appts? □ Yes □ No
    If yes, dosage & for what condition? _____
19. Is there a possibility you clench or grind your teeth? □ Yes □ No
    If yes, do you wear a Nightguard? _____
20. Have you ever been diagnosed with Sleep Apnea? □ Yes □ No
    Do you wear a CPAP or Nightguard? _____

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

□ Yes □ No Penicilllins or Amoxicillin
□ Yes □ No Other antibiotics _____
□ Yes □ No Codeine
□ Yes □ No Novocaine or other dental anesthetics
□ Yes □ No Latex
□ Yes □ No Other drugs or medicine _____

List all current medications and dosages (including over the counter meds like Aspirin or supplements, birth control, blood thinners, etc)

_____
_____
_____
_____
_____

Have you ever had any of the following: If yes, please add any details.

YES	NO	
□	□	Heart Disease or a Heart Attack
□	□	High Blood Pressure
□	□	Shortness of breath or tightness in the chest
□	□	Artificial or repaired heart valve When: _____
□	□	Bleeding trouble, anemia, or leukemia
□	□	Blood transfusion
□	□	Asthma Date of last attack _____
□	□	Emphysema, COPD, chronic cough, or other lung trouble
□	□	Current or past history of Tuberculosis/T.B.?
□	□	Ulcer or Gastric bleeding history
□	□	Artificial joint or prosthesis When: _____
□	□	HIV Positive or AIDS
□	□	Seizure, Epilepsy, or Fainting Spells
□	□	Hepatitis, Jaundice, or Liver Disease
□	□	Kidney Disease or Dialysis
□	□	Diabetes Type: _____ HbA1c: _____
□	□	Osteoporosis or Osteopenia
		History of bone density treatment? _____
□	□	Treatment for alcohol or drug dependency
□	□	Mental Health Condition If yes, please describe:
		_____
□	□	Recurrent cold sores or canker sores
□	□	Autoimmune condition _____
□	□	Cancer, radiation or chemotherapy
□	□	Pregnant, breast feeding, or possibly pregnant
□	□	Any other medical condition: _____
□	□	Hospitalizations or Surgeries: _____
		_____
		_____

Height _____ **Weight** _____ **Age** _____

Preferred Pharmacy _____

I hereby acknowledge that all the above information is true and accurate.

Signature _____

Reviewed By _____