



Dedicated To Excellence In Periodontics & Implantology

\*The following information will make it possible for us to be more successful and thorough in your treatment. Your answers are for our records only and will be considered confidential.

Name of Patient: \_\_\_\_\_  
First Middle Last (Nickname)

Today's Date: \_\_\_\_\_ Referring Dentist: \_\_\_\_\_

Reason for Referral (in your own words): \_\_\_\_\_

\*If patient is a minor- Name of Father: \_\_\_\_\_  
(or) Name of Mother: \_\_\_\_\_

Address: \_\_\_\_\_  
(Street) (Unit #)

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ E-Mail: \_\_\_\_\_

How would you prefer we contact you? Home phone Cell Phone E-Mail Other: \_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender: M F Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Marital Status: \_\_\_\_\_

-----  
Current Occupation: \_\_\_\_\_ Name of Employer: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Work Address (City, State): \_\_\_\_\_

Name of Spouse (if married): \_\_\_\_\_

Spouse's Occupation/ Employer: \_\_\_\_\_

Person Responsible for Payment: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Dental Insurance Co: \_\_\_\_\_ Group #: \_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ ID #: \_\_\_\_\_



### Medical & Dental History

- |   |     |    |         |
|---|-----|----|---------|
| 12. Do you have a dental phobia?  | Yes | No | Unknown |
| 13. Are you now, or have you ever been treated for a nervous depressive, or mental disorder?  | Yes | No | Unknown |
| 14. Do you currently take Aspirin, Coumadin or any other "blood thinning" drugs?  | Yes | No | Unknown |
| 15. Are you now, or have you ever taken a Bisphosphonate (bone sparing) drug for the treatment of Osteoporosis or Osteopenia? The most common are: Fosomax, Boniva, Actonel, Aredia, and Zometa | Yes | No | Unknown |

- 
16. Have you ever been told that you need to take antibiotics prior to a dental visit for a heart condition or joint replacement?      Yes      No      Unknown
17. Are you currently experiencing any dental pain?      Yes      No      Unknown
18. When was the last time you had your teeth cleaned? \_\_\_\_\_
19. Have you ever had a "deep cleaning" before?      Yes      No      Unknown
20. Please list all medications you are currently taking. Be sure to include all prescription, over-the-counter, and recreational medications as well as all vitamins and supplements:  
(write on back of attached form if you need more room)

**Medication:** \_\_\_\_\_ **Dose:** \_\_\_\_\_ **Frequency:** \_\_\_\_\_

21. Have you been told by your doctor to avoid taking Ibuprofen, Penicillin, Vicodin or any other specific medications?      Yes      No      Unknown

If yes, which: \_\_\_\_\_

22. Please list any other medical/ dental conditions (not included on this form) that you would like us to know about: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Women Only

- |  |     |    |         |
|--|-----|----|---------|
| 23. Are you pregnant/ Could you be pregnant? | Yes | No | Unknown |
| 24. Are you taking Birth Control Pills?      | Yes | No | Unknown |
| 25. Have you reached Menopause?              | Yes | No | Unknown |

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Today's Date

**Medical & Dental History**

**Office Use Only:**

Initial Visit BP: \_\_\_\_\_/\_\_\_\_\_ HR: \_\_\_\_\_ Sp%O2: \_\_\_\_\_ ASA: \_\_\_\_\_

**Updated:** \_\_\_\_\_ **Change:** \_\_\_\_\_ **Patient's Signature** \_\_\_\_\_

\_\_\_\_\_