ASSOCIATES IN PERIODONTICS
periodontics and dental implants

Date: _____ / _____ / _____
mm dd yy

PATIENT INFORMATION

Patient's Full Name: _____ Date of Birth: _____ / _____ / _____
(*First name, middle name and last name*) *mm dd yyyy*

Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Address: _____ City/ State/ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Preferred contact for appointment confirmation (check one): ☐ home ☐ work ☐ cell ☐ email

General DDS: _____ Whom may we thank for referring you? _____

EMPLOYMENT INFORMATION

Patient/ Parent

Employer: _____

Address: _____

City/ State/Zip: _____

Business Phone: _____

Social Security #: _____

Spouse/ Parent

Employer: _____

Address: _____

City/ State/Zip: _____

Business Phone: _____

Social Security #: _____

INSURANCE INFORMATION (Dental Only)

Name of Insured: _____ Insured DOB: _____ / _____ / _____
mm dd yyyy

Social Security # or ID# of Insured: _____ Group #: _____

Insurance Company's Address: _____ City/ State/ Zip: _____

CONSENT TO SERVICES

I consent to treatment necessary or desirable to the care of the patient first named above, for the diagnosis of dental disease, deformity, or treatment of dental emergency. These procedures may include radiographs, models, and intraoral examination. In the case of a dental emergency, I consent to the use of local anesthetic and relaxants for completing the necessary dental treatment. I also acknowledge full responsibility for the payment of such services and agree to pay for them, in full, at the time of service, unless other arrangements are made in advance.

I understand this office is required by law to maintain the privacy of my personal health information and provide me, upon request, with the legal duties and privacy practices with respect to my personal health information.

_____ _____ _____ / _____ / _____
Signature of patient, parent or guardian *Relationship to patient* *mm dd yy*

_____ _____ _____ / _____ / _____
Signature of patient, parent or guardian *Relationship to patient* *mm dd yy*

EMERGENCY CONTACT INFORMATION

Whom may we contact in case of an emergency? _____

Relationship to you: _____ Contact Phone: _____

DENTAL HISTORY & INFORMATION

Do your gums bleed when you brush or floss? ☐ Yes ☐ No

Are your teeth sensitive to cold, hot, sweets or pressure? ☐ Yes ☐ No

Does food or floss catch between your teeth? ☐ Yes ☐ No

Is your mouth dry? ☐ Yes ☐ No

Have you had any problems associated with previous dental treatment? ☐ Yes ☐ No

Date of last dental exam: _____ / _____ / _____

Do you have brux or grind your teeth? ☐ Yes ☐ No

Do you have sores or ulcers in your mouth? ☐ Yes ☐ No

Do you wear dentures or partials? ☐ Yes ☐ No

Have you ever had serious injury to your head or mouth? ☐ Yes ☐ No

Have you ever had orthodontic (braces) treatment? ☐ Yes ☐ No

What was done at the last dental exam? _____

Date of last dental x-rays: _____ / _____ / _____

What is the primary reason for your visit today? _____

MEDICAL HISTORY & INFORMATION

Family Physician: _____ Practice Name: _____

Address: _____ City/ State/ Zip: _____

Weight: _____ lbs (*required for local anesthesia*)

How is your current health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor Are you currently under the care of a physician? ☐ Yes ☐ No

Have you had a serious illness, operation or been hospitalized in the past 5 years? ☐ Yes ☐ No Is so, for what? _____

Are you currently taking or have you taken any prescription or over the counter medications? ☐ Yes ☐ No If yes, please list all, including vitamins, natural or herbal preparations and/ or diet supplements: _____

_____

Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? ☐ Yes ☐ No Date: _____ / _____ / _____

If yes, were there complications? ☐ Yes ☐ No

Are you currently taking or scheduled to begin taking either of the medications Alendronate (Fosamax) or risedronate (Actonel) for osteoporosis or Paget's disease? ☐ Yes ☐ No

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ☐ Yes ☐ No

Do you take controlled substances (drugs)? ☐ Yes ☐ No Do you use tobacco of any kind? ☐ Yes ☐ No

For Women Only Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Please mark all that apply:

Allergies

- ☐ Aspirin
- ☐ Codeine
- ☐ Dental Anesthetic
- ☐ Erythromyein
- ☐ Jewelry
- ☐ Latex
- ☐ Metals
- ☐ Penicillin
- ☐ Sulfa
- ☐ Tetracycline

Conditions:

- ☐ Alcohol abuse
- ☐ Allergies
- ☐ Anemia
- ☐ Angina Pectoris
- ☐ Arthritis
- ☐ Artificial heart
- ☐ Asthma
- ☐ Bisphosphonates
- ☐ Blood thinners
- ☐ Blood transfusion
- ☐ Cancer/Chemo
- ☐ Congenital heart defect
- ☐ Diabetes
- ☐ Difficulty breathing
- ☐ Drug abuse
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting spells
- ☐ Fever blisters
- ☐ Frequent headaches
- ☐ Glaucoma
- ☐ HIV +/ AIDS
- ☐ Hay fever
- ☐ Heart attack
- ☐ Heart disease
- ☐ Heart surgery
- ☐ Hemophilia
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ High blood pressure
- ☐ Kidney problems
- ☐ Liver disease
- ☐ Low blood pressure
- ☐ Mitral valve
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Pace maker
- ☐ Premed – heart
- ☐ Premed - joint
- ☐ Psychiatric problems
- ☐ Radiation therapy
- ☐ Rheumatic fever
- ☐ Seizures
- ☐ Sinus problems
- ☐ Stroke
- ☐ Thyroid problems
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal disease

Other conditions/ problems not listed: _____

_____