Precision Periodontics and Implant Dentistry
Daniel S. Lauer, DMD PA

PATIENT INFORMATION

Dr., Mr., Mrs., Ms., Miss (please circle one) Date_____

Full Name _____If patient is a minor, parent/guardian name _____

Date of birth_____What name would you like to be called _____ SS# _____

Home address _____ City _____State____ Zip _____ Phone (___)_____

Email _____ Cell Phone (___)_____ Pager (___)_____

Business address _____ City _____State____ Zip _____ Phone(___) _____

Employer's Name _____ Occupation _____

Dental Insurance Name: _____Dental Insurance Provider Number:_____

Name of subscriber: _____ Relation to subscriber: _____Date of Birth: _____

Subscriber ID#: _____ Group Name: _____Group #: _____

Subscriber Employer: _____ Occupation: _____ Business Phone:_____

Name of dentist _____ Location _____ How long? _____

Name of physician _____ Location _____ How long? _____

Whom may we thank for referring you to our office? _____

Reason for visit _____

Since periodontal disease is caused by a combination of many complex elements, it is necessary to resolve every possible contributing factor. The success of therapy is most dependent upon this. Though some of the following questions may seem unrelated to your condition, they are all associated with proper management of your oral health. Your answers are for our records only and will be considered confidential.

1. Are you in good health?……Yes ___ No ___
2. Date of last physical examination _____ Are you currently being treated by a physician?…….. Yes ___ No ___
3. Are you taking any prescription drugs or medications?…… Yes ___ No ___
   If yes, please list _____
4. Have you ever been prescribed PREMEDICATION antibiotics to use for dental treatment?.....Yes____No_____
5. Are you taking any over-the-counter preparations or medications (example: aspirin; vitamins)?……Yes ___ No ___
   If yes, please list _____
6. Are you allergic to latex or any other medications or substances ? ……..Yes ___No ____
   If yes, please list _____
7. Have you had any serious illness, operation, or been hospitalized?……..Yes ___ No ___
   If yes, please explain _____
8. Indicate which of the following you have had or have at the present:

Heart Failure	Yes ___ No ___	Asthma	Yes ___ No ___	Blood transfusion	Yes ___ No ___
Heart Disease or attack	Yes ___ No ___	Allergies or hives	Yes ___ No ___	Bruise easily	Yes ___ No ___
High blood pressure	Yes ___ No ___	Sinus trouble	Yes ___ No ___	Immune system disorder	Yes ___ No ___
Angina	Yes ___ No ___	Thyroid disease	Yes ___ No ___	AIDS/ARC/HIV positive	Yes ___ No ___
Heart murmur	Yes ___ No ___	Liver disorder	Yes ___ No ___	Fatigue	Yes ___ No ___
Rheumatic or scarlet fever	Yes ___ No ___	Hepatitis	Yes ___ No ___	Recent weight loss	Yes ___ No ___
Mitral valve prolapse	Yes ___ No ___	Diabetes	Yes ___ No ___	Fainting or dizziness	Yes ___ No ___
Congenital heart lesions	Yes ___ No ___	Hypoglycemia	Yes ___ No ___	Epilepsy or seizures	Yes ___ No ___
Artificial heart valve	Yes ___ No ___	Arthritis or rheumatism	Yes ___ No ___	Cancer	Yes ___ No ___
Heart pacemaker	Yes ___ No ___	Osteoporosis	Yes ___ No ___	Chemotherapy	Yes ___ No ___
Heart surgery	Yes ___ No ___	Skin disease	Yes ___ No ___	Radiation treatment	Yes ___ No ___
Artificial joints (hip, knee)	Yes ___ No ___	Glaucoma	Yes ___ No ___	Mental disorder	Yes ___ No ___
Stroke	Yes ___ No ___	Cold sores/fever blisters	Yes ___ No ___	Anxiety	Yes ___ No ___
Chest pain	Yes ___ No ___	Venereal disease	Yes ___ No ___	Drug addiction	Yes ___ No ___
Swollen ankles	Yes ___ No ___	Blood disease	Yes ___ No ___	Alcohol addiction	Yes ___ No ___
Shortness of breath	Yes ___ No ___	Anemia	Yes ___ No ___		
Kidney disorder	Yes ___ No ___	Prolonged bleeding	Yes ___ No ___		
Ulcers	Yes ___ No ___	___			
Tuberculosis	Yes ___ No ___	Hemophilia	Yes ___ No ___		
Emphysema	Yes ___ No ___	___			
Persistent cough	Yes ___ No ___				

(OVER)

9. Do you have any disease, condition, or problem not listed? ……Yes___ No ___
   If yes, please explain _____
10. Have you ever been prescribed medication for osteoporosis, osteopenia, or any systemic bone disorders?.....Yes____No___
11. Do you currently or have a history of smoking or using smokeless tobacco? …… Yes ___ No ___
12. Date of last dental visit _____
13. Have you had any problems associated with previous dental treatment? ……Yes ___ No ___
14. Have you ever had periodontal treatment?…… Yes ___ No ___
15. Have you ever worn braces?……..Yes ___ No ___

16. Do you clench or grind your teeth?……Yes ___ No ___
17. Do you experience pain in your jaw joints or facial muscles?…….. Yes ___ No ___
18. Do you wear any removable dental appliances?……Yes ___ No ___
19. Do you have any specific questions or concerns about your oral health?……Yes ___ No ___
If yes, please explain _____
20. How many alcoholic beverages do you consume per week?

WOMEN:

21. Are you pregnant?……Yes ___ No ___
22. Are you taking birth control pills?……Yes ___ No ___
23. Have you reached menopause?…… Yes ___ No ___

RELEASE

I understand that accurate and complete diagnosis is an essential first step in my dental care and authorize Dr. Lauer to perform diagnostic procedures as may be necessary to achieve an accurate and complete diagnosis. I also understand that effective diagnosis and treatment may necessitate the involvement of other health professionals in my care and therefore authorize Dr. Lauer to: 1. Request my (or my child's) previous medical or dental records and/or 2. Release any information concerning my (or my child's) health care, advise, and treatment to another dentist or physician.

I understand that responsibility for payment of dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered, unless financial arrangements have been made. I would appreciate the office's assistance in submitting my claims to my insurance company for reimbursement. I authorize release of any information concerning my (or my child's) health care, advise, or treatment provided for the purpose of evaluating and administering claims for insurance benefits and for securing payment for treatment. I also authorize payment of insurance benefits to be made directly to Dr. Lauer's office.

_____ _____

Print Name | Signature of patient (parent or guardian, if minor) | Date

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For completion by the doctor

PMH: _____

_____

PSHx: _____

Med: _____ Smk_____

Dental: _____ Perio _____

Occl: _____ Symp _____

Rest: _____ Goal _____

Comments: _____

_____

_____

Medical History Update:

Date	Comments	Signature

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