

Precision Periodontics and Implant Dentistry
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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 FailureYes ___ No ___ Asthma.....Yes ___ No ___ Blood transfusion Yes ___ No ___
Heart Disease or attackYes ___ No ___ Allergies or hives.....Yes ___ No ___ Bruise easily Yes ___ No ___
High blood pressureYes ___ No ___ Sinus trouble.....Yes ___ No ___ Immune system disorder Yes ___ No ___
AnginaYes ___ No ___ Thyroid disease.....Yes ___ No ___ AIDS/ARC/HIV positive Yes ___ No ___
Heart murmur.....Yes ___ No ___ Liver disorderYes ___ No ___ Fatigue.....Yes ___ No ___
Rheumatic or scarlet feverYes ___ No ___ Hepatitis.....Yes ___ No ___ Recent weight loss.....Yes ___ No ___
Mitral valve prolapseYes ___ No ___ DiabetesYes ___ No ___ Fainting or dizziness Yes ___ No ___
Congenital heart lesions.....Yes ___ No ___ Hypoglycemia.....Yes ___ No ___ Epilepsy or seizures.....Yes ___ No ___
Artificial heart valveYes ___ No ___ Arthritis or rheumatism .Yes ___ No ___ CancerYes ___ No ___
Heart pacemakerYes ___ No ___ OsteoporosisYes ___ No ___ ChemotherapyYes ___ No ___
Heart surgery.....Yes ___ No ___ Skin diseaseYes ___ No ___ Radiation treatment Yes ___ No ___
Artificial joints (hip, knee).....Yes ___ No ___ Glaucoma.....Yes ___ No ___ Mental disorderYes ___ No ___
StrokeYes ___ No ___ Cold sores/fever blisters Yes ___ No ___ AnxietyYes ___ No ___
Chest painYes ___ No ___ Venereal diseaseYes ___ No ___ Drug addiction.....Yes ___ No ___
Swollen anklesYes ___ No ___ Blood disease.....Yes ___ No ___ Alcohol addiction Yes ___ No ___
Shortness of breath.....Yes ___ No ___ AnemiaYes ___ No ___
Kidney disorder.....Yes ___ No ___ Prolonged bleedingYes ___ No ___
UlcersYes ___ No ___
TuberculosisYes ___ No ___ HemophiliaYes ___ No ___
Emphysema.....Yes ___ No ___
Persistent coughYes ___ 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 ___

