

**MEDICAL and DENTAL HISTORY:**

**PERIODONTAL & IMPLANT ASSOCS., PA**

This information is requested in order that I may thoroughly diagnose and treat your condition safely.

**Patient** \_\_\_\_\_ **Spouse Name** \_\_\_\_\_ **Date** \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Bus. Phone \_\_\_\_\_ Cell \_\_\_\_\_ Martial Status \_\_\_\_\_

**Email** \_\_\_\_\_ **DOB** \_\_\_\_\_ **SS #** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ **Weight** \_\_\_\_\_ **Height** \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Physician/s \_\_\_\_\_ Phone \_\_\_\_\_

Dentist \_\_\_\_\_ Phone \_\_\_\_\_ Referred By \_\_\_\_\_

**Insured Name** \_\_\_\_\_ **DOB** \_\_\_\_\_ **SS#** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Employer \_\_\_\_\_ Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Name of Dental Insurance \_\_\_\_\_ Person Responsible for payment \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

	YES	NO	ARE YOU:	YES	NO		YES	NO
<b>Hepatitis A, B, C</b> .....			Presently under the care of a physician?.....			Sleep Apnea.....		
Epilepsy.....			Date of last physical.....			Slow healing.....		
Kidney Disease.....			<b>Please List Medication Names:</b>			Smoke pack/day.....		
<b>Diabetes</b> .....			_____			If no, when stopped.....		
Often thirsty.....			_____			E cigarettes.....		
<b>Autoimmune Disease/HIV</b> ..			_____			<b>Drink coffee</b> per day.....		
Heart Trouble/Atrial Fib.....			_____			<b>Drink alcohol</b> per day.....		
<b>High Blood Pressure</b> .....			<b>Surgeries:</b> _____					
Chest Pains.....			_____			<b>DENTAL:</b>		
Shortness of Breath.....			<b>Unfavorable reaction to a drug: Such as:</b>			A mouth breather.....		
Stroke.....			Aspirin.....			Aware of grinding or clenching.....		
Prolonged Bleeding.....			Versed.....			Treated for gum disease.....		
<b>Cancer, Type</b> .....			Dental Anesthetics.....			Had braces/orthodontics.....		
Radiation Treatment.....			Penicillin.....			Jaw popping or pain.....		
Psychiatric Treatment.....			Sulfa Drugs.....			Bad breath.....		
Stomach Ulcers.....			Fentanyl.....			Bleeding gums.....		
Asthma.....			Hydrocodone.....			Tooth sensitivity.....		
<b>If yes, Inhaler</b> .....			Codeine.....			Heat/Cold		
<b>Osteopenia/porosis</b> .....			Other.....			Family member lost teeth.....		
Arthritis.....			<b>Prostrate trouble</b> .....			Who?		
Thyroid.....			<b>Pregnant</b> .....			Use water pik.....		
Tuberculous.....			Menopause.....			Taught oral hygiene care.....		
			Past menopause.....			Tooth loss concern.....		
						Considered implants.....		
						Reason for your visit today?.....		

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