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
Hepatitis A, B, C.....		
Epilepsy.....		
Kidney Disease.....		
Diabetes.....		
Often thirsty.....		
Autoimmune Disease/HIV..		
Heart Trouble/Atrial Fib.....		
High Blood Pressure.....		
Chest Pains.....		
Shortness of Breath.....		
Stroke.....		
Prolonged Bleeding.....		
Cancer, Type.....		
Radiation Treatment.....		
Psychiatric Treatment.....		
Sinus Problems.....		
Stomach Ulcers.....		
Asthma.....		
If yes, Inhaler.....		
Osteopenia/porosis.....		
Arthritis.....		
Thyroid.....		
Tuberculous.....		

ARE YOU:	YES	NO
Presently under the care of a physician?.....		

Date of last physical_____

Please List Current Medication Names:

_____

_____

_____

_____

_____

_____

Have you taken Bisphosphonates		

Surgeries: _____

_____

Unfavorable reaction to a drug: Such as:	YES	NO
Aspirin.....		
Versed.....		
Dental Anesthetics.....		
Penicillin.....		
Sulfa Drugs.....		
Fentanyl.....		
Hydrocodone.....		
Codeine.....		
Other.....		
Prostate trouble.....		
Pregnant.....		
Menopause.....		
Past menopause.....		

	YES	NO
Been told have **MRSA**		
Sleep Apnea/mouth breather..		
Slow healing.....		
Smoke pack/day.....		
If no, when stopped.....		
E cigarettes.....		
Drink coffee per day.....		
Drink alcohol per day.....		

DENTAL:	YES	NO
Aware of grinding or clenching.		
Treated for gum disease.....		
Had braces/orthodontics.....		
Jaw popping or pain.....		
Bad breath.....		
Bleeding gums.....		
Tooth sensitivity..... Heat/Cold		
Family member lost teeth..... Who?_____		
Use water pik.....		
Taught oral hygiene care.....		
Tooth loss concern.....		
Considered implants.....		

Reason for your visit today?_____

_____

_____

Patient Signature_____