PERSONAL RECORDS UPDATE

Please print. Date _____

Please answer the following completely. Your answers are for our records and they are considered confidential.

Patient's Name _____ **Weight** _____ **Age** _____

Marital Status _____ **Date of Birth** _____ **S.S.#** _____

Name of Spouse _____ **Patient Email address** _____

If a Child, Parent's Name(s) _____ **Weight of Child** _____

Residence Address _____ **City** _____ **State** _____ **Zip** _____

Telephone:Residence _____ **Business**: _____ **Cell**: _____

Employed By: _____ **Business Address**: _____

Spouse Employed By: _____ **Business Tel:** _____

Whom may we thank for referring you? _____

Person Responsible for Payment of Account _____
(*and address if different than above*)

Emergency Contact Info:

Person to contact in case of an emergency _____ **Telephone** _____

Dental Insurance Info:

(WE DO NOT FILE MEDICAL OR MEDICAID INSURANCE OR SECONDARY INSURANCE)

Subscriber: _____ **S.S.#/ID #:** _____ **DOB:** _____

Group #: _____ **Employer:** _____ **Ins. Company:** _____

Ins. Co. Address: _____ **City**: _____

State: _____ **Zip**: _____ **Ins. Co. Telephone Number**: _____
(Please provide copy of dental insurance card at appointment if available)

Patient's relationship to insured: ☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **Other** _____

HEALTH QUESTIONNAIRE

Answers to the following questions are for our records and will be considered confidential.

1. **Are you presently under the care of a physician?** ☐ **Yes** ☐ **No** **Name and address of physician** _____
_____ **Phone** _____ **If so for what condition are you being treated?** _____

2. **Have you had abnormal bleeding associated with previous extractions, surgery or trauma?** ☐ **Yes** ☐ **No**

3. **Are you allergic to or have you reacted adversely to:**

a.	☐ **Yes** ☐ **No**	**Local Anesthetics (Novocaine)?**	**d.**	☐ **Yes** ☐ **No**	**Penicillin or other antibiotics?** _____
b.	☐ **Yes** ☐ **No**	**Aspirin?**	**e.**	☐ **Yes** ☐ **No**	**Codeine or other narcotics?** _____
c.	☐ **Yes** ☐ **No**	**Nitrous oxide analgesia?**	**f.**	☐ **Yes** ☐ **No**	**Latex?**

4. **Do you wear a pacemaker?** ☐ **Yes** ☐ **No** **Do you have vascular stents?** ☐ **Yes** ☐ **No** **Date placed?** _____

5. **Do you take aspirin on a daily basis?** ☐ **Yes** ☐ **No** **NOTE: Aspirin is a medication. Taking aspirin on a daily basis can affect possible surgical treatment.**

6. **Are you a smoker?** ☐ **Yes** ☐ **No** **Approximately, how much?** _____

7. **Have you ever taken any of the diet medications known as Fen-Phen, or Redux?** ☐ **Yes** ☐ **No**
If yes, was a heart problem diagnosed after using this medication? ☐ **Yes** ☐ **No**

8. **Have you taken Cortisone within the past year?** ☐ **Yes** ☐ **No** **When and how long?** _____

Please turn over for additional questions

9. Do you drink alcohol? ☐ Yes ☐ No How frequently do you drink alcohol? _____

How many drinks do you consume at a time? _____ What type of alcohol? _____

Do You Have or Have You Ever Had: (*check those which apply*)

___Heart problems
___High blood pressure
___Artificial heart valve replace.
___Joint replacement
___Rheumatic Fever
___Heart Murmur
___Anemia
___Bacterial endocarditis

___Cancer
___Liver disease
___Hepatitis
___Jaundice (Yellow skin)
___Stroke
___Tuberculosis
___Lung Trouble
___Pain in chest
___Shortness of breath

___Diabetes
___Kidney or bladder trouble
___Prolonged bleeding
___Thyroid trouble
___Asthma
___HIV+
___Glaucoma
___Fainting or Dizziness
___Epilepsy or Convulsions

___Stomach trouble/Intestinal
___Arthritis
___Psychological problems
___Alcoholism or Drug addiction
___Other

What medications are you taking or have you taken in the past year? _____

_____

Please describe any current medical treatment, impending operations, or any other medical or dental information that may affect your periodontal care.

WOMEN

1. Are you pregnant? ☐ Yes ☐ No
2. Are you presently taking birth control pills? ☐ Yes ☐ No Hormones? ☐ Yes ☐ No
3. Have you reached menopause? ☐ Yes ☐ No

Patient's Signature _____ Date _____

Periodontist's signature _____ Date _____