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PRACTICE LIMITED TO PERIODONTICS

DIPLOMATE AMERICAN BOARD OF PERIODONTOLOGY

DATE ____________

PATIENT INFORMATION

First Name _____________________ Last Name ____________________ Preferred Name ______________

Date of Birth ____/_____/_____ Sex (please circle) M / F Marital Status___________

Mailing Address ____________________________ City ________________ State________ Zip Code __________

Home Phone (_____) ______-________ Cell Phone (_____) ______-________ Work (_____) ______-_______

Social Security Number _______-_____-________ Employer ______________________________________

General Dentist _____________________ Referred By ____________________

Email Address ____

INSURANCE

Name of Insured _________________________ Insured Social Security Number _______-_____-________

Insured Date of Birth _____ /_____ /_____ Relation to Patient _____________________

PRIMARY DENTAL INSURANCE

Insurance Company ________________________________ Address ___________________________________

Insurance Telephone Number (____) ______-_______ ID# _________________ Group Number_______________

SECONDARY DENTAL INSURANCE

Insurance Company________________________________ Address ___________________________________

Insurance Telephone Number (____) ______-_______ ID# _________________ Group Number_______________

PLEASE COMPLETE BOTH SIDES OF FORM.

PATIENT NAME ___________________________ **DATE___________________**

MEDICAL CONTACTS

Medical Doctor's First and Last Name ___________________ Doctor's Telephone (_____) ______-________

Emergency Contact Name __________________ Cell Phone (_____) ______-________ Relation __________

MEDICAL CONDITIONS

Please circle if you have or have had any of the following.

Aids (HIV pos)	Allergies	Alzheimer's Disease	Anemia	Atrial Fibrillation
Artificial Heart Valve	Artificial Joints / Hips	Emphysema	Chemotherapy / Radiation	Diabetes
Easily Bruise	Cancer	TB (Tuberculosis)	Parkinson's disease	Low Blood Pressure
Congenital Heart Lesion	Glaucoma	Drug Addiction	Excessive Thirst	Pacemaker
Epilepsy or Seizures	Heart Murmur	Hepatitis A, B, C	Hemophilia	Respiratory Problems
Hypoglycemia	Liver Disease	Psychiatric Care	High Blood Pressure	Heart Surgery Kidney
Problems	Thyroid Problems	X-Ray Treatment	Heart Trouble	Mitral Valve Prolapse
Pain in Jaw Joints	Osteoporosis	Other: ____________________		

Are you a smoker? ________

MEDICATIONS

List ALL current medications and supplements:

____________________ ____________________ ____________________ ____________________

____________________ ____________________ ____________________ ____________________

____________________ ____________________ ____________________ ____________________

Do you have a medical condition or a physician that requires you to be pre-medicated (take antibiotics) prior to dental procedures? If yes, please explain. ____

List any allergies to medications/substances:

Aspirin Penicillin Sulfa Codeine Morphine Steroids Erythromycin
Tetracycline Dental Anesthetics Latex Other: _________________

___________________________________ ____________
Patient Signature (Parent/Guardian/Representive) Date

___________________________________ ____________
Staff Signature Date