MEDICAL HISTORY

Height_____ Weight_____ How do you describe your health? ___Good ___Fair ___Poor
Physician's Name_____ Phone:_____ Date of Last Visit _____
Have you had any serious illnesses or operations in the past 2 years? _____Yes _____No
If Yes, please describe_____
Have you ever had a blood transfusion? _____Yes _____No Approx. date _____ (Women) Are you pregnant? _____Yes _____No
Emergency Contact – Name_____ Phone_____

Please check if you have or have had any of the following:

__Anemia	__Cancer	__Heart Murmur	__Latex allergy	__Shortness of breath
__Anorexia/Bulimia	__Chemotherapy	__Heart problems	__Liver disease	__Smoking/snuff habit
__Arthritis	__Cortisone treatments	__Hemophilia	__Mitral Valve Prolapse	__Stroke
__Artificial heart valve	__Diabetes	__Hepatitis	__Pacemaker	__Swelling/feet/ankles
__Artificial joints	__Epilepsy	__High blood pressure	__Radiation treatment	__Thyroid problems
__Asthma	__Fainting	__HIV pos/Aids	__Respiratory disease	__Tuberculosis
__Autoimmune disease	__Glaucoma	__Jaw pain	__Rheumatic fever	__Ulcers
__Breast augmentation	__Headaches	__Kidney disease	__Scarlet Fever	

__NONE OF THE ABOVE

PLEASE CIRCLE YOUR ANSWER:

Do you require antibiotics prior to dental appointments? Yes No
Are you taking blood thinners (other than aspirin)? Yes No

MEDICATIONS:

List Medications you are currently taking:

_____
_____
_____

Have you taken the diet medications Fen/Phen and/or Redux? ___Yes___No
Do you take or have you taken osteoporosis/bisphosphonate medication? ___Yes ___No

MEDICATION ALLERGIES:

___None
___Aspirin
___Barbiturates (sleeping pills)
___Codeine
___Local Anesthetic
___Penicillin
___Sulfa
___Other_____

DENTAL HISTORY

General Dentist: _____ Date of Last dental exam/cleaning_____
Do you have a parent who has lost all or most of their teeth? ____Yes ____No How often do you floss? _____ Brush?_____

Have you had, or are you having any problems with the following?

__Appearance of teeth __Gum boils/abscesses __Loose teeth __Teeth shifting __Sensitive to hot/cold/sweets (Circle those that apply)	__Sores or growths in mouth __Abnormal bleeding from extraction __Pain ___at present? __Clicking/popping of the jaw __Frightening dental experience	__Sensitivity to biting __Bleeding gums __Dry mouth/burning tongue __Food collecting between teeth __Other	__Bad breath or taste __Orthodontic treatment __Periodontic treatment __Clenching/grinding teeth

FINANCIAL AGREEMENT

- As a courtesy to our patients, we will gladly bill your insurance when complete information is provided.
- Insurance estimates are **ESTIMATES ONLY**, therefore, your deposit may not cover your portion of the payment. The patient or responsible party is responsible for payment of all claims regardless of insurance coverage.
- I have reviewed the above and understand that I am responsible for the entire balance and for complying with any payment arrangements set up by your office. I further understand that any balance over 120 days old will be subject to a 1.5% per month service charge and I will be liable for any fees incurred in the collection of a delinquent account.
- I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.
- The above information is accurate and complete to the best of my knowledge. I will not hold my periodontist or any of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature_____ **Reviewed by**_____

Date_____ **Date**_____