Periodontic & Implantology Associates

Periodontics • Implantology • Oral Plastic Surgery

NOTES:

ANNUAL RECORDS UPDATE

DATE _____

Patient's Last Name	**First Name**	**M.I.**	**Cell Phone** ( )
Street Address	**City, State, Zip**		**Business Phone** ( )
Has your dental insurance changed since your last visit? ☐ No ☐ Yes *Please complete the following:*			**Home Phone** ( )
Name of Insured Person	**Birth Date of Insured**	**Social Security No. of Insured**	**Relationship of Insured Person** ☐ Self ☐ Spouse ☐ Parent or Guardian
Name of Dental Insurance Co.	**Group Number**		**Employer**
Do You Have Additional Dental Insurance? ☐ No ☐ Yes **Name of Insured Person**	**Birth Date of Insured**	**Social Security No. of Insured**	**Relationship of Insured Person** ☐ Self ☐ Spouse ☐ Parent or Guardian
Name of Dental Insurance Co.	**Group Number**		**Employer**
Patient Email	**In Case of Emergency Notify - Name, Telephone**		
General Dentist	**Phone No. ( )**		**Date of Last Appointment:** / /

MEDICAL UPDATE

Please circle YES or NO

☐ YES ☐ NO Do you consider your medical health to be good? When did you have your last medical check-up? Date _____

☐ YES ☐ NO Are you taking ANY medications/vitamins, i.e. fish oil, etc., (prescription or non-prescription) regularly? PLEASE LIST: _____

_____

☐ YES ☐ NO Do you normally premedicate with ANTIBIOTICS prior to dental treatment?

☐ YES ☐ NO Are you being treated by a medical doctor at this time? For what? _____

☐ YES ☐ NO Have you ever had an injury to your face or jaw?

☐ YES ☐ NO Do you smoke or chew tobacco? How much?_____ YES NO Do you consume alcohol? How much? _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

☐ YES ☐ NO Heart Disease *(heart valve replacement, mitral valve prolapse, bypass surgery, pacemaker, heart murmur, stent, angioplasty, etc.)*

☐ YES ☐ NO Rheumatic Fever

☐ YES ☐ NO Osteoporosis medications *(ie. Fosamax, Boniva, Prolia)*

☐ YES ☐ NO Joint Replacement - Hip, Knee, _____

☐ YES ☐ NO Bleeding Problems (inability to clot)

☐ YES ☐ NO Blood Disease (anemia, leukemia, sickle cell)

☐ YES ☐ NO Blood Thinners (Plavix, Coumadin, Xarelto, Eliquis)

☐ YES ☐ NO Blood Pressure: High Low

☐ YES ☐ NO Cancer

☐ YES ☐ NO Radiation Treatments

☐ YES ☐ NO Diabetes

☐ YES ☐ NO Lung Disease, *TB, COPD Asthma, Emphysema, etc.*

☐ YES ☐ NO Kidney Disease

☐ YES ☐ NO Liver Disease

☐ YES ☐ NO Hepatitis A B C (circle one)

☐ YES ☐ NO Epilepsy or Seizures

☐ YES ☐ NO Ulcers

☐ YES ☐ NO Arthritis

☐ YES ☐ NO Sinus Trouble

☐ YES ☐ NO Glaucoma

☐ YES ☐ NO Psychiatric Treatment

☐ YES ☐ NO AIDS or HIV

☐ YES ☐ NO Are you pregnant?

☐ YES ☐ NO Do you take oral contraceptives?

☐ YES ☐ NO Are you allergic to or react to any medications or drugs (penicillin, aspirin, codeine, lidocaine, etc.)? _____

_____

☐ YES ☐ NO Do you have other allergies (LATEX, foods, etc.)? _____

☐ YES ☐ NO Do you use recreational drugs (ie cocaine, etc.)?

☐ YES ☐ NO Are you ever short of breath on mild exertion?

☐ YES ☐ NO Have you been hospitalized recently? WHY? _____ WHEN? _____

☐ YES ☐ NO Have you had any surgeries recently or in the past year? _____

Please describe any other medical or dental treatment you are going to receive that the doctor should know about.

_____

Pharmacy Name_____Phone_____

Signed _____ Signed _____

Patient or Legal Guardian *D.D.S.*