Periodontic & Implantology Associates

Periodontics • Implantology • Oral Plastic Surgery

NOTES:

Patient Registration

Date _____

1. Patient's Last Name	2. First Name	3. M.I.	4. Cell Phone ( )
5. Street Address	6. City, State, Zip		7. Business Phone ( )
8. Legal Sex ☐ F ☐ M ☐ Non-Binary Preference: ☐ She, Her(s) ☐ He, Him, His ☐ They, Them, Theirs		9. Marital Status	10. Home Phone ( )
11. Patient's Date of Birth	12. Patient's Social Security #	13. Drivers License #	
14. Do you have Dental Insurance? ☐ YES ☐ NO	15. Dental Insurance Co.	16. Group Number	17. Policyholder Employer
18. Policyholder Name	19. Policyholder Date of Birth	20. Policyholder Social Security #	21. Relationship to Policyholder ☐ Self ☐ Spouse ☐ Parent or Guardian
22. Do you have additional Dental Insurance? ☐ YES ☐ NO	23. Additional Dental Insurance Co.	24. Group Number	25. Policyholder Employer
26. Policyholder Name	27. Policyholder Date of Birth	28. Policyholder Social Security #	29. Relationship to Policyholder ☐ Self ☐ Spouse ☐ Parent or Guardian
30. Patient Email	31. In Case of Emergency Notify Name	Phone No. ( )	

Medical History

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 Have you ever ☐smoked, ☐chewed tobacco, ☐vaped? 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 mumur, 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 Sleep Apnea

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 in the past year? _____

Please DESCRIBE ANY other medical treatment, recent, impending or scheduled operations or other medical or dental information that the doctor should know about.

Signed _____ *Patient or Legal Guardian*

Signed _____ *D.D.S.*

Dental History

YES NO Are you experiencing pain, discomfort, or sensitivity from your mouth at this time?

YES NO Have you had swollen areas of the gums?

When did you last have your teeth cleaned? Date _____

How often do usually have your teeth cleaned? _____

YES NO Have you ever had gum (periodontal) treatments?

YES NO Do your gums bleed?

YES NO Are you aware of any loose teeth presently?

YES NO Have you noticed any bad mouth odors or tastes?

YES NO Do you use dental floss daily?

YES NO Have you ever worn braces (orthodontic treatment)?

YES NO Are you satisfied with the appearance of your teeth?

YES NO Are you now under more nervous tension than usual?

YES NO Are you aware of clenching, gritting, or grinding your teeth? _____ Day _____ Night

YES NO Do you have headaches regularly?

YES NO Do you frequently have pain about your ears, temples, or neck?

YES NO Do you chew on only one side of your mouth? If so, why? _____

YES NO Have you ever had prolonged bleeding following extractions in the past?

YES NO Do you ever have canker sores and/or herpetic cold sores?

YES NO Have you ever had treatment for a tumor, growth, or cancer in or around your mouth?

YES NO Did either parent lose all their teeth (i.e. family history of periodontal disease)?

Who referred you to our office? _____

General Dentist _____ How Long? _____ Phone No. _____

Who is responsible or guarantees payment for treatment? _____

Relationship of patient _____ Date of Birth _____

SS# _____ Driver's License# _____

Name of your Medical Physician _____ Phone _____

Pharmacy Name _____ Phone _____