DFW PERIODONTICS

IMPLANT DENTISTRY

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PATIENT INFORMATION FORM

NAME_____________________________________NICKNAME_________________

PHONE(CELL)_______________PHONE(WK) ________________PHONE (HM)___________

ADDRESS__________________________APT_____CITY___________ZIP CODE_________

S.S. #________________AGE_______D.O.B.__________

PLACE OF EMPLOYMENT___________________________OCCUPATION_______________

SPOUSE/PARENT NAME_______________________WORK NUMBER_____________

S.S. #________________D.O.B._____________________

EMAIL____

WHOM MAY WE CONTACT IN CASE OF AN EMERGENCY?______________PHONE__________

PHYSICIAN_____________________________PHONE_______________

GENERAL DENTIST_____________________PHONE_______________

HOW DID YOU HEAR ABOUT OUR OFFICE?______________________

DO YOU HAVE DENTAL INSURANCE? YES____NO___MEDICAL INSURANCE? YES___NO___

DENTAL HISTORY

CHIEF COMPLAINT____

DO YOU:	YES	NO
HAVE PAIN IN YOUR MOUTH….................	____	____
WHERE_____________________________		
HAVE FREQUENT HEADACHES…………	____	____
HAVE POPPING OR CLICKING JOINTS IN FRONT OF YOUR EARS………………	____	____
HAVE PAIN IN THE JOINTS IN FRONT OF		
CLENCH OR GRIND TEETH..................	____	____
HAVE FREQUENT PROBLEMS WITH BAD BREATH………………………………………	____	____

WHEN WERE YOU FIRST TOLD OF YOUR GUM PROBLEMS___________________________

USE TOBACCO PRODUCTS: WHICH AND HOW MUCH?_______________________________

DRINK ALCOHOL: HOW MUCH?________________

USE RECREATIONAL DRUGS?____________________

HAVE YOU:	YES	NO
HAD GUM SURGERY.............................……..	____	____
HAD PERIODONTAL SCALING..……..........	____	____
NOTICED BLEEDING GUMS WHEN YOU BRUSH……………………………………........	____	____
HAVE ANY TEETH SHIFT RECENTLY…........	____	____
HAD ORTHODONTICS (BRACES) ……...........	____	____
EVER HAD A SERIOUS INJURY OR BLOW TO YOUR MOUTH………………………...........	____	____
HAD YOUR WISDOM TEETH REMOVED…...	____	____
IF YES, WHEN_______________________		

DENTAL CARE

HOW OFTEN DO YOU HAVE DENTAL CLEANINGS AND CHECK-UPS____________________________

WHEN WAS YOUR LAST CLEANING?______________

(CONTINUED ON BACK)

MEDICAL HISTORY

DATE OF LAST DOCTOR APPT________________

HEIGHT______________WEIGHT______________

DO YOU HAVE, HAVE YOU HAD:

	YES	NO
HEPATITIS OR LIVER DISEASE…….	____	____
EPILEPSY, CONVULSIONS OR SEIZURES………………………. …	____	____
RHEUMATIC FEVER……………...........	____	___
KIDNEY OR BLADDER DISEASE……	____	____
DIABETES………………………………	____	____
TUBERCULOSIS OR EMPHYSEMA…	____	____
HEART ATTACK………………………	____	____
HEART TROUBLE……………………..	____	____
HEART MURMUR……………………..	____	____
STROKE………………………………..	____	____
HIGH/LOW BLOOD PRESSURE……	____	____
SHORTNESS OF BREATH……………	____	____
SWOLLEN ANKLES……………………	____	____
CHEST PAINS (ANGINA) ……………..	____	____
ALLERGIES……………………………..	____	____
CANCER………………………………..	____	____
CHEMOTHERAPY/RADIATION THERAPY………………………………	____	____
HOSPITALIZATION FOR ILLNESS OR INJURY……………………………..	____	____
SURGERY……………………………….	____	____
GLAUCOMA…………………………....	____	____
HEMOPHILIA…………………………..	____	____
ARTHRITIS……………………………..	____	____
LUPUS…………………………………..	____	____
PSYCHIATRIC TREATMENT……..….	____	____
THYROID TROUBLE…………………..	____	____
STOMACH ULCERS………………..…..	____	____
SINUS PROBLEMS……………………..	____	____
ASTHMA………………………………...	____	____
ANEMIA………………………………...	____	____
HEART VALVE REPLACEMENT……. .	____	____
HIP OR KNEE REPLACEMENT…….....	____	____
OTHER PROSTHETIC DEVICE…….....	____	____
HIV POSITIVE…………………………..	____	____
AIDS……………………………………..	____	____
HIGH RISK FOR HIV INFECTION…..... (E.G. INTRAVENOUS DRUG USE, OR BLOOD TRANSFUSION)	____	____

ANY SERIOUS ILLNESS NOT LISTED?__________________

____

LIST ALL MEDICATIONS AND DOSES YOU TAKE NOW

____

____

____

PLEASE ADD ANYTHING YOU FEEL IS IMPORTANT_______

____

IF FEMALE, ARE YOU NOW:	**YES**	**NO**
PREGNANT…………………… …...	____	____
TAKING BIRTH CONTROL………. .	____	____
THROUGH MENOPAUSE…………..	____	____

DO YOU HAVE/HAVE YOU HAD AN UNFAVORABLE REACTION TO:

ASPIRIN…………………………………	____	____
BARBITUATES…………………………	____	____
SCOPOLAMINE…………………….....	____	____
GENERAL ANESTHESIA……………...	____	____
LOCAL (DENTAL) ANESTHETIC…….	____	____
PENICILLIN OR AMOXICILLIN……...	____	____
ERYTHROMYCIN……………………..	____	____
TETRACYCLINE OR DOXYCYCLINE.	____	____
OTHER ANTIBIOTICS…………….....	____	____

IF YES WHICH ONES__________________

CODEINE………………………………..	____	____
DEMEROL………………………………	____	____
VICODIN………………………………..	____	____
OTHER PAIN MEDICATIONS………..	____	____
ANY OTHER DRUGS…………………	____	____

WHICH______________________________

ARE YOU:

PRESENTLY UNDER A PHYSICIAN'S CARE……………………………………	____	____

TAKING ANY MEDICATIONS OR WITH IN THE PAST YEAR SUCH AS:

ANTIBIOTICS………………………....	____	____
ANTICOAGULANTS…………………..	____	____
ANTIDEPRESSANTS…………………	____	____
ASPIRIN………………………………..	____	____
BLOOD PRESSURE MEDICATION….	____	____
CORTISONE/OTHER STEROID……	____	____
DIABETES TABLETS………………	____	____
HORMONE MEDICATION……………	____	____
INSULIN..………………………………	____	____

OTHER:

SUBJECT TO FREQUENT URINATION……………………………	____	____
OFTEN THIRSTY………………………	____	____
SUBJECT TO PROLONGED BLEEDING AFTER INJURY TO TOOTH OR EXTRACTION……………………..	____	____

HAVE YOU EVER TAKEN PRESCRIPTION DIET PILLS (FEN-PHEN, REDUX)………….	____	____
HAVE YOU EVER TAKEN ANY OF THE MEDS: FOSAMAX(osteoporosis), BONEFOS, ZOMETA, AREDIA, ACTONEL……………………	_____	____

I confirm that all of the above information is correct to the best of my knowledge.

X________________________________

PATIENT'S OR LEGAL GUARDIAN'S SIGNATURE