Periodontics and Implants

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www.NorthlakePerioandImplants.com

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PATIENTS'S NAME_____

HOME ADDRESS _____
STREET CITY STATE ZIP

_____
HOME PHONE WORK PHONE CELL PHONE

PATIENT'S SS# _____ PATIENTS'S DATE OF BIRTH _____

EMPLOYER _____ MALE _____ FEMALE _____ SINGLE _____ MARRIED _____

ADDRESS _____

WHOM MAY WE THANK FOR REFERRING YOU ? _____

NAME OF FAMILY DENTIST _____ DATE OF LAST CLEANING_____

NAME OF YOUR PHYSICIAN _____ PHONE # _____

NAME OF EMERGENCY CONTACT_____ PHONE #_____

ARE YOU ALLERGIC TO OR HAVE HAD A REACTION TO ANY OF THE FOLLOWING? (Please circle)

Aspirin	Iodine	Thorazine	Biaxin
Codeine	Local Anesthetic	Probanthine	Cipro
Fosamax	Valium	Penicillin	Keflex
Demerol	Percodan	Erythromycin	Other Antibiotics
Tylenol	Nitrous Oxide (laughing gas)	Clindamycin	Latex Allergy
Motrin/Advil	Phenergan	Tetracycline	Sulfa

ARE YOU ALLERGIC TO ANY OTHER MEDICATION? (Circle) Yes No If yes, please list_____

DO YOU SMOKE CIGARETTES? (Circle) Yes No If yes, how many packs per day_____

FOR WOMEN: Are you pregnant? (Circle) Yes No Are you taking birth control pills? (Circle) Yes No (Taking antibiotics may inactivate birth control pills)

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING? (Please Circle)

Heart disease or attack	Stroke	Epilepsy or seizures	Fainting or dizzy spells
Heart murmur	Kidney trouble	Cancer	Hepatitis
Irregular heartbeat	Ulcers	Arthritis	Liver disease
Mitral valve prolapse	High blood pressure	Glaucoma	Blood transfusion
Artificial heart valve	Emphysema	Pain in jaw joints	Hemophilia
Heart pacemaker	Tuberculosis (TB)	Excessive bleeding	Bruise easily
Heart surgery	Asthma	Anemia	Sexually transmitted diseases
Orthopedic implant	Sinus trouble	Alcoholism	Fever blisters (herpes)
Organ transplant	Pollen allergies	Substance abuse problem	AIDS or related
Acid Reflux	Diabetes	Neurologic disorder	HIV or related
Osteoporosis	Thyroid disease	Psychiatric treatment	Hearing disorder

DO YOU HAVE ANY OTHER MEDICAL CONDITIONS? (Circle) Yes No If yes, please list_____

_____

LIST ANY PRESCRIBED MEDICATIONS YOU ARE CURRENTLY TAKING _____

_____

_____

ARE YOU PRESENTLY TAKING OR HAVE YOU IN THE PAST TAKEN FOSAMAX, ACTONEL, BONIVA, ZOMETA OR A SIMILAR DRUG?
(Circle) Yes No If yes, please list drug and length of time taking the medication _____

APPOINTMENTS: Once an appointment is made, please remember this time has been reserved for you. Without 24-hour notification, you may incur a charge for failed or cancelled appointments.

PATIENT (OR GUARDIAN'S) SIGNATURE_____ DATE _____