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.*