PERIODONTAL MEDICINE
Surgical Specialists, LLC
Personalized | Preventative | Predictable | Proven

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PATIENT INFORMATION				
Patient's Last Name	First	Middle	☐ Mr. ☐ Mrs.	☐ Sr.
			☐ Dr. ☐ Miss	☐ Jr.
Street Address		City	State	Zip Code
Phone Number		Email Address		
Birth Date	**Age**	**SSN**	**Marital Status**	**Sex**
/ /			☐ Single ☐ Mar ☐ Widow ☐ Div	☐ M ☐ F

DENTAL INSURANCE INFORMATION				
Occupation	Insured Employer			
Insured Employer Address				
Please indicate insurance company	Address of insurance carrier		Phone number	
Insured Name	Insured SSN	Insured ID	Policy Group #	Eff. date
				/ /
Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other			**Insured Birth Date:** / /	

MEDICAL INSURANCE INFORMATION				
Occupation	Insured Employer			
Insured Employer Address				
Please indicate insurance company	Address of insurance carrier		Phone number	
Insured Name	Insured SSN	Insured ID	Policy Group #	Eff. date
				/ /
Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other			**Insured Birth Date:** / /	

FAMILY PHYSICIAN INFORMATION

Primary Doctor's Name	Specialty	Phone Number	City	State	Zip Code
Other Doctor's Name	**Specialty**	**Phone Number**	**City**	**State**	**Zip Code**

RESTORATIVE DENTIST INFORMATION

Doctor's Name		Phone Number	
Street Address	**City**	**State**	**Zip Code**

Whom may we thank for referring you? ☐ Doctor/Dentist ☐ Family/Friend ☐ Other

ALLERGIES (LIST KNOWN ALLERGIES AND REACTIONS TO DRUGS/MEDICATIONS)

☐ Penicillin ☐ Sulfa Drugs ☐ Clindamycin ☐ Local Anesthetic ☐ Barbiturates, sedatives
☐ Aspirin ☐ Iodine ☐ Latex ☐ Codeine

☐ NO KNOWN ALLERGIES ☐ NO KNOWN DRUG ALLERGIES
☐ Other known drug allergies, Please list:

☐ Other allergies (food, adhesives, tapes, Band-Aids, etc.), Please list:

☐ Please list type of reaction for allergies indicated:

MEDICATIONS (PLEASE LIST CURRENT MEDICATIONS THAT YOU ARE TAKING: PRESCRIPTION AND OVER-THE-COUNTER)

MEDICATION	DOSE	MEDICATION	DOSE

Alcoholic beverage consumption: ☐ No ☐ Yes
(If yes, # drinks per week:)

Tobacco Usage: ☐ No ☐ Yes
(If yes, # pack(s)/day: Duration:)

Last medical examination:
HEIGHT: WEIGHT:

Women: Are you pregnant? ☐ Yes ☐ No
Are you nursing? ☐ Yes ☐ No

Do you have any problems associated with your menstrual cycle? ☐ Yes ☐ No

Have you ever had sedation or general anesthesia in the past? ☐ Yes ☐ No
If yes, List any complications:

CHIEF DENTAL COMPLAINT?
Are you experiencing pain at this time? ☐ No ☐ Yes, Location: Duration of pain:

Please Indicate Previous Dental Treatment You Have Had:

☐ Surgery ☐ Orthodontics ☐ Treatment w/ Oral Medicine specialist ☐ Endodontics (root canal therapy)

Indicate which of the following you have had or have at present. Check Yes or No for each item			
Arthritis/Rheumatism	☐Yes ☐No	Sinus trouble or Hay fever	☐Yes ☐No
Artificial Joints If yes, Date placed:	☐Yes ☐No	HIV Positive or AIDS	☐Yes ☐No
Asthma If yes, last attack:	☐Yes ☐No	Kidney Trouble	☐Yes ☐No
Diabetes: ☐Type I ☐Type II ☐History of gestational Daily blood sugar: HgA1C: Date:	☐Yes ☐No	Are you currently taking (or have ever taken) a bisphosphonate drug? (Actonel, Fosamax, etc.) Medication: Duration:	☐Yes ☐No
Do you have a cardiac pacemaker?	☐Yes ☐No	Osteoporosis, Osteopenia If yes, T-score: ☐>2.5 ☐1.5-2.5	☐Yes ☐No
Abnormal bleeding, Anemia	☐Yes ☐No	Epilepsy, Neurological Disorders	☐Yes ☐No
Cardiovascular Disease (heart trouble, heart attack, angina, coronary insufficiency/occlusion, high blood pressure, arteriosclerosis, stroke, valve replacement)	☐Yes ☐No	Diagnosed Sleep Apnea Do you use a CPAP or BIPAP machine?	☐Yes ☐No ☐Yes ☐No
Cancer If yes, Type: Treatment received: ☐Radiation ☐Chemotherapy ☐Surgery	☐Yes ☐No	Stomach Problems ☐Acid Reflux ☐Heartburn ☐GERD ☐Ulcer	☐Yes ☐No
Liver Disease, Hepatitis, or jaundice	☐Yes ☐No	Psychological disorders/Mental Health Problems	☐Yes ☐No
Respiratory problems, emphysema, bronchitis, etc.	☐Yes ☐No	Tuberculosis or persistent cough	☐Yes ☐No
Do you wear contact lenses?	☐Yes ☐No	Sexually transmitted diseases:	☐Yes ☐No
Low blood pressure	☐Yes ☐No	Thyroid disorders: Hypo/Hyper/Other:	☐Yes ☐No

Do you have any first degree relatives with a history of Diabetes? If yes, what type?
☐Mother ☐Father ☐Brother ☐Sister Type:

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of their staff, responsible for any errors that I have made in the completion of this form.

x	/ /
Patient/Guardian Signature	Date (mm/dd/yy)

It is sometimes necessary to consult with other healthcare related professionals and/or institutions in order to have the best information concerning your oral health. This form gives your authorization to requsest pertinent records about your past medical and dental history.

I hereby authorize any physician, dentist, or facility that has any record or knowledge of my health to give Periodontal Medicine & Surgical Specialists, LTD. any such information. A photographic/digital copy of this authorization shall be valid as original.

I understand that any balance over 60 days past de will be subject to a 1% per month finance charge and that I may be liable for any third party collection and/or attorney fees icurred in collecting the delinquent balance.

x	/ /
Patient/Guardian Signature	Date (mm/dd/yy)