Periodontics of Greenville

Date _____

Please complete this form in print and bring with you to your next appointment:

Name _____ Preferred Name " _____ "

Social Security # _____

Date of Birth_____ Marital Status _____Height _____ Weight _____Sex _____

Home Address _____

City _____ State_____ Zip _____ E-mail _____

Home (_____)_____- _____ Mobile (_____) _____ - _____ Work (_____) _____ - _____

Please note: By listing above contact information, you agree for our office to utilize this information to contact you regarding any communication.

Dental Insurance Company*: _____ **Please present card for duplication*

Insured's Employer:_____

Insured's Name, SSN and DOB (if other than patient):_____

Name and Address of Responsible Party (if other than patient)

Name _____

Address _____

Referred by _____ General Dentist's Name _____

Have you, or any family member, ever been a patient of this office? Yes No

If yes, name of family member and relationship to patient _____

Emergency Contact_____Phone _____

*****Please note: By listing a contact person above, you agree for our office to disclose any and all pertinent information regarding your care to this person in the event of an emergency.***

Please describe reason for this visit:

_____

_____

Patient Medical History

General Physician _____ Phone _____Date of last exam _____

1. Are you under the care of **another physician**?..... Yes No
   If Yes, Why? _____
2. Have you ever been **hospitalized** for any surgical operation or serious illness?..... Yes No
   If Yes, When? _____
3. Have you been in any other institution (weight reduction, drug or alcohol treatment, mental, psychiatric, or other) in the last three years?..... Yes No
   Explain _____
4. Are you taking any **medications** or **supplements**?..... Yes No
   If yes, What?_____
5. Please circle any of the following medications for **Osteoporosis** you have taken in the last 12 months:
   Fosamax Boniva Actonel Zometa Aredia Bonefos Didronel Other: _____
6. Are you currently taking any **blood thinners** (this includes Plavix, Aspirin, Coumadin)?..... Yes No
   If yes, What?_____

Please turn page over and continue

7. Have you ever been instructed by a doctor **to pre-medicate with antibiotics** prior to going to the dentist due to a joint replacement or a heart condition? ..... Yes No
8. Are you currently using **tobacco** products? ..... Yes No
9. Do you drink **alcohol**? ..... Yes No
10. Do you use **recreational drugs**? ..... Yes No
11. Are you **allergic** to any drugs or medicine (including anesthesia)? ..... Yes No
    If yes, which one(s)? _____
12. Are you **allergic** to latex or any rubber products? ..... Yes No
13. Are you allergic to milk, eggs, or any other food products? ..... Yes No
    If yes, which one(s)? _____
14 Women only
    a. Are you pregnant or think you may be pregnant? ..... Yes No
    b. Are you nursing? ..... Yes No
    c. Are you taking birth control pills, hormones or using female contraceptives? ..... Yes No

Do you have or have you had any of the following?

Cardiovascular

High Blood Pressure ..... Yes No
Heart Disease ..... Yes No
Rheumatic Fever ..... Yes No
Heart Attack ..... Yes No
Mitral Valve Prolapse/Murmur ..... Yes No
Cardiac Pacemaker ..... Yes No
Angina / Chest Pains ..... Yes No
Heart Infection / Endocarditis ..... Yes No
Heart Surgery / Stents ..... Yes No
Peripheral Vascular Neuropathy ..... Yes No

Respiratory

Asthma ..... Yes No
Shortness of Breath ..... Yes No
Emphysema ..... Yes No
Tuberculosis ..... Yes No
Chronic Obstructive Pulmonary Disease ..... Yes No

Neurologic

Fainting / Seizures ..... Yes No
Epilepsy / Convulsions ..... Yes No
Stroke ..... Yes No
Transient Ischemic Attacks (TIAs) ..... Yes No
Fibromyalgia ..... Yes No

Infectious Disease / Immune Problems

Organ Transplant ..... Yes No
AIDS or HIV Infection ..... Yes No
Hepatitis: Circle Type A B C ..... Yes No
Infectious / Sexually Transmitted Disease ..... Yes No
MRSA / VRSA ..... Yes No

Endocrine

Diabetes ..... Yes No
Thyroid / Parathyroid Problems ..... Yes No
Liver Disease ..... Yes No
Jaundice ..... Yes No

Cancer / Blood Disorders

Cancer ..... Yes No
Type: _____
Radiation Therapy or Chemotherapy ..... Yes No
Which Area: _____
Anemia ..... Yes No

Stomach / Intestinal Problems

Irritable Bowel Syndrome ..... Yes No
Colitis, Diverticulitis ..... Yes No
Crohn's Disease ..... Yes No
Acid Reflux ..... Yes No
Peptic Ulcer Disease ..... Yes No

Other

Swollen Ankles ..... Yes No
Kidney Disorders or Stones ..... Yes No
Arthritis ..... Yes No
Joint Replacement / Joint Implants ..... Yes No
Frequently Tired ..... Yes No
Hay Fever / Allergies ..... Yes No
Glaucoma ..... Yes No
Recent Weight Loss ..... Yes No
Any Adverse Reactions to Anesthesia ..... Yes No
Sleep Apnea ..... Yes No
Other condition(s) not mentioned above _____

*****If you are a regular blood donor, please check with your blood donation center regarding their guidelines for donation after receiving bone grafting*****

Authorization and Release

I certify that I have read and understand the above information and, to the best of my knowledge, all questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my dependent during the period of such Dental care to third party payers and/or health practitioners.

x _____
Signature of patient or parent if minor