

Periodontics of Greenville

Date _____

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

Name _____ Preferred Name " _____ "

Social Security # _____ Employer _____

Date of Birth _____ Marital Status _____ Height _____ Weight _____ Gender _____

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 you have **ever** taken for **Osteoporosis**:
Fosamax Boniva Actonel Zometa Aredia Didronel Reclast Prolia Xgeva

6. Are you currently taking any **blood thinners** (this includes Plavix, Aspirin, Coumadin, Xarelto, Aggrenox, Effient, Eliquis)? .. 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		Endocrine	
High Blood Pressure.....	Yes No	Diabetes	Yes No
Heart Disease.....	Yes No	Thyroid / Parathyroid Problems.....	Yes No
Rheumatic Fever	Yes No	Liver Disease.....	Yes No
Heart Attack.....	Yes No	Jaundice	Yes No
Mitral Valve Prolapse/Murmur	Yes No	Cancer / Blood Disorders	
Cardiac Pacemaker.....	Yes No	Cancer.....	Yes No
Angina / Chest Pains.....	Yes No	Type: _____	
Heart Infection / Endocarditis	Yes No	Radiation Therapy or Chemotherapy	Yes No
Heart Surgery / Stents.....	Yes No	Which Area: _____	
Peripheral Vascular Neuropathy.....	Yes No	Anemia	Yes No
Respiratory		Stomach / Intestinal Problems	
Asthma	Yes No	Irritable Bowel Syndrome	Yes No
Shortness of Breath.....	Yes No	Colitis, Diverticulitis.....	Yes No
Emphysema.....	Yes No	Crohn's Disease	Yes No
Tuberculosis	Yes No	Acid Reflux	Yes No
Chronic Obstructive Pulmonary Disease.....	Yes No	Peptic Ulcer Disease	Yes No
Neurologic		Other	
Fainting / Seizures.....	Yes No	Swollen Ankles	Yes No
Epilepsy / Convulsions	Yes No	Kidney Disorders or Stones.....	Yes No
Stroke	Yes No	Arthritis	Yes No
Transient Ischemic Attacks (TIAs).....	Yes No	Joint Replacement / Joint Implants.....	Yes No
Fibromyalgia	Yes No	Frequently Tired.....	Yes No
Infectious Disease / Immune Problems		Hay Fever / Allergies	Yes No
Organ Transplant.....	Yes No	Glaucoma	Yes No
AIDS or HIV Infection	Yes No	Recent Weight Loss	Yes No
Hepatitis: Circle Type A B C.....	Yes No	Any Adverse Reactions to Anesthesia.....	Yes No
Infectious / Sexually Transmitted Disease.....	Yes No	Sleep Apnea	Yes No
MRSA / VRSA.....	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