Parkway Periodontal Group

GENERAL INFORMATION

Answers to all questions are for office use only and are strictly confidential.

Name: _____ Birth Date: _____ Age: _____ □ Male □ Female

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Business Phone: _____ Cell Phone: _____

E-mail address: _____ Soc. Sec. #: _____Marital Status: _____

Occupation: _____Employer: _____

Spouse (or Parents/Guardian) – Name: _____Employer: _____

Emergency Contact: _____ Phone Number: _____

Do you have dental insurance? □ Yes □ No Dental Insurance Co.: _____

Policy Holder – Name: _____ SS # or ID#: _____Birth Date: _____

General Dentist: _____ Referred By: _____

Physician's Name: _____ Address: _____

MEDICAL HISTORY

Are you being treated by a □ physician or a □ psychiatrist now? □ Yes □ No

Date of last physical exam: _____ Height: _____ Weight: _____

Please mark an "X" in the box if you have/had any of the following:

□ Rheumatic Fever	□ Arthritis	□ Drug Addiction
□ Angina/Chest Pains	□ Osteoporosis/Osteopenia	□ Alcoholism
□ Heart Murmur	□ Bleeding Problems (anemia)	□ Venereal Disease
□ Heart Valve Replacement	□ Hemophilia	□ Herpes
□ High Blood Pressure	□ Joint Replacement	□ HIV, AIDS
□ Low Blood Pressure	□ Liver Disorder (jaundice, hepatitis)	□ Glaucoma
□ Heart Attack	□ Stomach Problems (ulcers)	□ Depression
□ Mitral Valve Prolapse	□ Diabetes	□ Sinus Problems
□ Pace Maker	□ Skin Disease (hives)	□ Blood Transfusion
□ Kidney Disorder	□ Lupus	□ Epilepsy, Seizures
□ Dialysis	□ Leukemia	□ Cancer (type) _____
□ Lung Problems (tuberculosis, COPD)	□ Thyroid Disease	□ Other_____
□ Asthma	□ Stroke	

Have you ever been seriously ill or hospitalized? □ Yes □ No If yes, explain: _____

Are you taking any medication or herbal supplements? □ Yes □ No

If yes, please list: _____

_____

Are you allergic to or have any unusual reaction to any medications? □ Yes □ No

If yes, please list: _____

Have you ever taken or are you currently taking any bisphophonate medications (i.e.Boniva, Fosamax)? □ Yes □ No

If yes, are you aware of the dental risks associated with these medications? □ Yes □ No

Do you require antibiotic premedication prior to any dental appointments? □ Yes □ No

Do you currently smoke or chew tobacco? □ Yes □ No If yes, how much: _____ how long: _____

Women, are you pregnant at the present time? □ Yes □ No

I certify that the above information is accurate. I will notify the doctor of any change in my health or medication.

Date: _____

Patient/Guardian Signature: _____

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