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**Diplomate, American Board of Periodontology**

09/14

PATIENT'S NAME \_\_\_\_\_ BIRTHDATE \_\_\_\_\_

HOME ADDRESS \_\_\_\_\_  
STREET CITY STATE ZIP

HOME# WK# CELL# E-MAIL

PATIENT'S SS# \_\_\_\_\_ MALE \_\_\_\_ FEMALE \_\_\_\_ SINGLE \_\_\_\_ MARRIED \_\_\_\_

EMPLOYER NAME/ADDRESS \_\_\_\_\_

WHOM MAY WE THANK FOR REFERRING YOU? \_\_\_\_\_

NAME OF FAMILY DENTIST \_\_\_\_\_ DATE OF LAST CLEANING \_\_\_\_\_

NAME OF YOUR PHYSICIAN \_\_\_\_\_ PHONE# \_\_\_\_\_

NAME OF EMERGENCY CONTACT \_\_\_\_\_ PHONE# \_\_\_\_\_

ARE YOU ALLERGIC TO OR HAVE HAD A REACTION TO ANY OF THE FOLLOWING? (Please Check)

- |                                       |   |                                       |  |
|---------------------------------------|---|---------------------------------------|--|
| <input type="checkbox"/> Aspirin      | <input type="checkbox"/> Local Anesthetic             | <input type="checkbox"/> Thorazine    | <input type="checkbox"/> Cipro         |
| <input type="checkbox"/> Codeine      | <input type="checkbox"/> Valium                       | <input type="checkbox"/> Probanthine  | <input type="checkbox"/> Keflex        |
| <input type="checkbox"/> Fosamax      | <input type="checkbox"/> Percodan                     | <input type="checkbox"/> Penicillin   | <input type="checkbox"/> Other         |
| <input type="checkbox"/> Demerol      | <input type="checkbox"/> Nitrous Oxide (laughing gas) | <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Antibiotics   |
| <input type="checkbox"/> Tylenol      | <input type="checkbox"/> Phenergan                    | <input type="checkbox"/> Clindamycin  | <input type="checkbox"/> Latex Allergy |
| <input type="checkbox"/> Motrin/Advil |   | <input type="checkbox"/> Tetracycline | <input type="checkbox"/> Sulfa         |
| <input type="checkbox"/> Iodine       |   | <input type="checkbox"/> Biaxin       |  |

ARE YOU ALLERGIC TO ANY OTHER MEDICATION? (Circle) Yes No If yes, please list \_\_\_\_\_

DO YOU SMOKE CIGARETTES? (Circle) Yes/ No If yes, how many packs per day \_\_\_\_\_

FOR WOMEN: Are you pregnant? (Circle) Yes / No Are you taking birth control pills? (Circle) Yes /No

**(Taking antibiotics may inactivate birth control pills)**

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING? (Please Check)

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> Heart disease          | <input type="checkbox"/> Acid Reflux         | <input type="checkbox"/> Thyroid disease         | <input type="checkbox"/> Psychiatric treatment         |
| <input type="checkbox"/> Heart attack           | <input type="checkbox"/> Osteoporosis        | <input type="checkbox"/> Epilepsy or seizures    | <input type="checkbox"/> Fainting or dizzy spells      |
| <input type="checkbox"/> Heart murmur           | <input type="checkbox"/> Osteopenia          | <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Hepatitis                     |
| <input type="checkbox"/> Irregular heartbeat    | <input type="checkbox"/> Stroke              | <input type="checkbox"/> Arthritis               | <input type="checkbox"/> Liver disease                 |
| <input type="checkbox"/> Mitral valve prolapse  | <input type="checkbox"/> Kidney trouble      | <input type="checkbox"/> Glaucoma                | <input type="checkbox"/> Blood transfusion             |
| <input type="checkbox"/> Artificial heart valve | <input type="checkbox"/> Ulcers              | <input type="checkbox"/> Pain in jaw joints      | <input type="checkbox"/> Hemophilia                    |
| <input type="checkbox"/> Heart pacemaker        | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Excessive bleeding      | <input type="checkbox"/> Bruise easily                 |
| <input type="checkbox"/> Heart surgery          | <input type="checkbox"/> Emphysema           | <input type="checkbox"/> Anemia                  | <input type="checkbox"/> Sexually transmitted diseases |
| <input type="checkbox"/> Orthopedic implant     | <input type="checkbox"/> Tuberculosis (TB)   | <input type="checkbox"/> Alcoholism              | <input type="checkbox"/> Fever blisters (herpes)       |
| <input type="checkbox"/> Organ transplant       | <input type="checkbox"/> Asthma              | <input type="checkbox"/> Substance abuse problem | <input type="checkbox"/> AIDS or related               |
|   | <input type="checkbox"/> Sinus trouble       | <input type="checkbox"/> Neurologic disorder     | <input type="checkbox"/> HIV or related                |
|   | <input type="checkbox"/> Pollen allergies    |  | <input type="checkbox"/> Hearing disorder              |
|   | <input type="checkbox"/> Diabetes            |  |  |

DO YOU HAVE ANY OTHER MEDICAL CONDITIONS? (Circle) Yes No If yes, please list \_\_\_\_\_

LIST ANY PRESCRIBED MEDICATIONS YOU ARE CURRENTLY TAKING \_\_\_\_\_

ARE YOU PRESENTLY TAKING OR HAVE YOU IN THE PAST TAKEN: FOSAMAX, ACTONEL, BONIVA, ZOMETA OR A SIMILAR DRUG? (Circle) Yes No If so, you may be at risk for osteonecrosis of the jaw (ONJ).

APPOINTMENTS: Once an appointment is made, please remember this time has been reserved for you.  
Without 24-hour notification, you may incur a charge for failed or cancelled appointments.

PATIENT (OR GUARDIAN'S) SIGNATURE \_\_\_\_\_ DATE \_\_\_\_/\_\_\_\_/\_\_\_\_