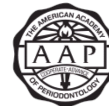
PERIODONTAL Medicine | Surgical SPECIALISTS LTD



ALAN ROSENFELD, DDS, FACD GEORGE MANDELARIS, DDS, MS BRADLEY DEGROOT, DDS, MS

## PATIENT INFORMATION

| Patient's Last Name | First | Middle | ☐ Mr. ☐ Mrs. ☐ Dr. ☐ Miss | ☐ Sr. ☐ Jr. |
|---|---|---|---|---|
| | | | | |

| Street Address | City | State | Zip Code |
|---|---|---|---|
| | | | |

| Home Phone # | Work Phone # | Cell Phone # | Email Address |
|---|---|---|---|
| ( ) - | ( ) - | ( ) - | |

I give my permission to be contacted on the phone number(s) and/or email address listed above
Voice messages regarding appointments and account status may be left on the following number(s): ☐Home ☐ Work ☐ Cell
Information regarding appointments/treatment/account status may be discussed with relationship

| Birth Date | Age | Social Security Number | 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 S. S. # | 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 S. S. # | Insured ID | Policy Group # | Eff. Date |
|---|---|---|---|---|
| | | | | |

Patient's Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other **Insured Birth Date** / /

## FAMILY PHYSICIAN INFORMATION

Primary Medical Doctor's Name Phone Number ( ) -
Street Address City State Zip Code

Other Doctor's Name Specialty Phone Number ( ) -
Street Address City State Zip Code

## RESTORATIVE DENTIST INFORMATION

| Doctors Name | Phone Number |
|---|---|
| | ( ) - |

Street Address City State Zip Code

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

# MEDICAL HISTORY

**ALLERGIES (LIST KNOWN ALLERGIES and REACTIONS TO DRUGS/MEDICATIONS)**

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

☐ Other known drug allergies, Please list: ☐ Other allergies (food, adhesives, tapes, bandaids 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, Drinks per week | Tobacco Usage: ☐ NO ☐ YES, Pack(s)/day Duration years

Last medical examination:
HEIGHT WEIGHT

**Women:** Are you Pregnant? ☐ Yes ☐ No | Are you Nursing? ☐ Yes ☐ No
Do you have any problems associated with your menstral 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 with an Oral Medicine specialist | ☐ Endodontics (root canal therapy)

**Indicate which of the following you have had or have at present. Check Yes or No to each item**

| | | | | | |
|---|---|---|---|---|---|
| Arthritis/Rheumatism | ☐ Yes | ☐ No | Sinus trouble or Hay fever | ☐ Yes | ☐ No |
| Artificial Joints: Date Placed | ☐ Yes | ☐ No | H.I.V. Positive or AIDS | ☐ Yes | ☐ No |
| Asthma: if yes, last attack: | ☐ Yes | ☐ No | Kidney Trouble | ☐ Yes | ☐ No |
| Diabetes: Type I, Type II or history of gestational (pregnancy)?<br>Daily Blood Sugar: HgA1C: date: | ☐ Yes | ☐ No | Are you currently taking (or have ever taken) a bisphosphonate drug? (Actonel, Fosamax, etc.)<br>Medication______ Duration________ | ☐ Yes | ☐ No |
| Do you have a cardiac pacemaker? | ☐ Yes | ☐ No | Osteoporosis, Osteopenia<br>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:<br>Do you Use a CPAP or BIPAP machine? | ☐ Yes<br>☐ Yes | ☐ No<br>☐ No |
| Cancer: if yes, Type<br>Treatment received:<br>☐ Radiation ☐ Chemotherapy ☐ Surgery | ☐ Yes | ☐ No | Stomach Problems<br>☐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 his/her staff, responsible for any errors that I have made in the completion of this form.

**X** / /

Patient/Guardian Signature Date

It is sometimes necessary to consult with other health care related professionals and/or institutions in order to have the best information concerning your oral health. This form gives your authorization to request 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 due 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 incurred in collecting the delinquent balance.

**X** / /

Patient/Guardian Signature Date