

SOUTHWIND
Periodontics & Dental Implants, P.A.

Please Complete Front and Back

Name _____ Date _____

Address _____ City _____ State _____ Zip _____

Social Security _____ Sex ___M___F Marital Status ___S___M___D Date of Birth _____

Employer _____ Work Phone _____ Home Phone _____ Cell Phone _____

Spouse's Name _____ Spouse's Employer _____ Your email address _____

Physician's Name _____ Address _____ Physician's Phone _____

Last Physical Examination _____ Findings _____

Dental Insurance Company _____ Policy # _____ Group # _____

Referred by: _____ Have family or friends been treated here? _____

Emergency contact name, phone #, and relationship: _____

Present Dental Concerns/Dental History Notes

DENTAL HISTORY

	YES	NO	
Do you fear dental treatment	___	___	Are your teeth sensitive to hot___cold___sweet___
Do your gums bleed	___	___	When was your last dental cleaning _____
Do you grind or clench your teeth	___	___	What interval are you having your teeth cleaned
Have you noticed your bite changing . . .	___	___	___3 mos ___ 4 mos ___6 mos ___12 mos
Have you been treated for periodontal disease	___	___	How long have you been a patient of your present dentist _____
Have you had treatment to straighten your teeth	___	___	How long have you known of your present gum condition _____
Has any member of your family lost all of their teeth	___	___	How would you rate your past dental care: ___ good ___ fair ___ poor
Have you had any "gum boils" or swellings	___	___	Please check any of the following items you use in mouth care:
Are you satisfied with the appearance of your teeth	___	___	Hand toothbrush _____ Stimulents _____
If no, why not _____			Electric toothbrush _____ Gum stimulator _____
			Proxabrush _____ Rubber tip _____
			Tooth pick _____ Perio aid _____
			Water spray device _____ Floss _____
			Brushing frequency _____
			Flossing frequency _____

MEDICAL HISTORY

	YES	NO		YES	NO
Hepatitis, jaundice, or liver disease	___	___	Substance abuse/alcoholism	___	___
Epilepsy, convulsion, fainting spells	___	___	Do you take aspirin, anticoagulants (blood thinners), fish oil, Omega 3, or flaxseed	___	___
Heart murmur	___	___	Do you wear contact lenses	___	___
Heart trouble or stroke	___	___	Do you bruise easily	___	___
History of high blood pressure	___	___	Hives or skin rash	___	___
History of high cholesterol	___	___	Do you use tobacco.....	___	___
Arteriosclerosis	___	___	If so, how much _____ How many years _____		
Shortness of breath	___	___	If male, prostate problems	___	___
Emphysema	___	___	If female:		
Chest pain	___	___	Pregnant or lactating	___	___
Swelling in ankles	___	___	Taking anti-pregnancy drug	___	___
Tuberculosis	___	___	Presently in menopause	___	___
Kidney disease or infection	___	___	Post-menopause	___	___
Diabetes	___	___	Osteoporosis/osteopenia	___	___
Any blood relative	___	___	Taking medications for osteoporosis/osteopenia	___	___
Arthritis or rheumatism	___	___	(i.e. Fosamax, other bisphosphonates)	___	___
Stomach or gastric disorder	___	___	Would you desire nitrous oxide		
Glaucoma	___	___	(laughing gas) for anxiety	___	___
Asthma, hay fever, or allergies	___	___			
Drug reaction to: ___ codeine, ___ demerol			Are you:		
___ percocet, ___ percodan, ___ LATEX			Presently under a physicians care	___	___
___ aspirin, ___ valium, ___ nitrous oxide			Taking any medication not listed	___	___
___ tetracycline, ___ penicillin, ___ erythromycin			Taking vitamins	___	___
other _____			Taking herbal supplements	___	___
Allergic to dental anesthetic	___	___	Aware of recent weight change	___	___
Thyroid or parathyroid disease	___	___	Often exhausted or fatigued	___	___
Venereal disease	___	___	Subject to frequent headaches	___	___
HIV/AIDS	___	___	A nervous person	___	___
Hospitalization for illness or surgery	___	___	Under unusual stress or tension	___	___
(Please note below)			Taking nerve or sleeping pills	___	___
Cancer or abnormal growth	___	___	Often unhappy or depressed	___	___
If yes, did you have radiation treatment			Taking antidepressant medication	___	___
or chemotherapy	___	___	Do you require antibiotic premedication		
Anemia or blood disorder	___	___	prior to dental procedures.	___	___
Abnormal bleeding problems	___	___	Reason: _____		
Do you have an artificial prosthesis	___	___			
Any serious illness not listed	___	___			
(Please note below)					

Medical History Notes

Please write below or attach a list of current medications and dosage: (including over the counter medications)

___ I CONSENT / ___ DO NOT CONSENT for my pre and post treatment photos to be used for educational purposes. (names are not listed with the photos and the photos are only of your mouth)

PATIENT SIGNATURE (parent signature if minor) _____