SOUTHWIND
Periodontics & Dental Implants, P.A.

Please Complete Front and Back

Patient's Name_____Date_____

Address_____ City_____State_____Zip_____

Patient's Social Security_____ Sex ____M _____F Date of Birth_____

Mother's Name and address_____Work Phone_____Home Phone_____

Father's Name and address_____Work Phone_____Home Phone_____

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?_____

Present Dental Concerns/Dental History Notes

_____

DENTAL HISTORY

	YES	NO
Do you fear dental treatment	____	____
Do your gums bleed	____	____
Do you grind or clench your teeth	____	____
Have you noticed your bite changing . . .	____	____
Have you been treated for periodontal disease	____	____
Have you had treatment to straighten your teeth	____	____
Has any member of your family lost all of their teeth	____	____
Have you had any "gum boils" or swellings	____	____
Are you satisfied with the appearance of your teeth	____	____

If no, why not_____

Are your teeth sensitive to hot___cold___sweet___

When was your last dental cleaning_____

What interval are you having your teeth cleaned

___3 mos ___ 4 mos ___ 6 mos ___12 mos

How long have you been a patient of your present dentist _____

How long have you known of your present gum condition_____

How would you rate past dental care:
___good ___ fair ___poor

Please check any of the following items you use in mouth care:

Hand toothbrush	___	Stimudents	___
Electric toothbrush	___	Gum stimulator	___
Proxabrush	___	Rubber tip	___
Tooth pick	___	Perio aid	___
Water spray device	___	Floss	___

Brushing frequency _____
Flossing frequency _____

MEDICAL HISTORY

	YES	NO
Hepatitis, jaundice, or liver disease	____	____
Epilepsy, convulsion, fainting spells	____	____
Heart murmur	____	____
Heart trouble or stroke	____	____
High blood pressure	____	____
Arteriosclerosis	____	____
Shortness of breath	____	____
Emphysema	____	____
Chest pain	____	____
Swelling in ankles	____	____
Tuberculosis	____	____
Kidney disease or infection	____	____
Diabetes	____	____
Any blood relative	____	____
Arthritis or rheumatism	____	____
Stomach or gastric disorder	____	____
Glaucoma	____	____
Asthma, hay fever, or allergies	____	____
Drug reaction to: ___ codeine, ___ demerol ___percocet, ____percodan ____aspirin,____ valium,____ nitrous oxide ____tetracycline,___ penicillin,____ erythromycin ____LATEX		
other _____	____	____
Thyroid or parathyroid disease	____	____
Venereal disease	____	____
HIV/AIDS	____	____
Hospitalization for illness or surgery	____	____
Hives or skin rash	____	____
Cancer or abnormal growth	____	____
If yes, did you have radiation treatment or chemotherapy	____	____
Anemia or blood disorder	____	____
Abnormal bleeding problems	____	____
Do you have an artificial prosthesis	____	____
Do you require antibiotic premedication prior to dental procedures	____	____

	YES	NO
Substance abuse/alcoholism	____	____
Do you take aspirin, anticoagulants (blood thinners), fish oil, Omega 3, or flaxseed	____	____
Do you wear contact lenses	____	____
Do you bruise easily	____	____
Do you smoke	____	____
If so, how much _____ How many years _____		
If male, prostate problems	____	____
If female:		
Pregnant or lactating	____	____
Taking anti-pregnancy drug	____	____
Presently in menopause	____	____
Post-menopause	____	____
Osteoporosis/osteopenia	____	____
Taking medications for osteoporosis/osteopenia ___ (i.e. Fosamax, other bisphosphonates) _____	___	___
Any serious illness not listed	____	____
Would you desire nitrous oxide (laughing gas) for anxiety	____	____

Are you:

Presently under a physicians care	____	____
Taking any medication not listed	____	____
Taking vitamins	____	____
Allergic to dental anesthetic	____	____
Aware of recent weight change	____	____
Often exhausted or fatigued	____	____
Subject to frequent headaches	____	____
A nervous person	____	____
Under unusual stress or tension	____	____
Taking nerve or sleeping pills	____	____
Often unhappy or depressed	____	____
Taking antidepressant medication	____	____
Taking herbal supplements	____	____

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 photos are only of your mouth)

Patient signature (parent signature if minor) _____