Periodontal Associates, Inc.

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ALL INFORMATION WILL BE HELD IN STRICT CONFIDENCE

Patient: ______________________ Home Tel. No: ______________________
Address: ______________________ Bus. No: ______________________
______________________ Cell No: ______________________
Spouse's Name: ______________________ Email: ______________________
Address: ______________________ Date of Birth: ______________________
(if different from yours)

Dentist: ______________________
Address: ______________________

Physician: ______________________
Address: ______________________

Have you been tested for HIV or Aids virus?______________ If so, are you HIV positive?______________

MEDICATIONS YOU ARE TAKING AT THIS TIME: ______________________

HAVE YOU HAD PRIOR :	YES	NO	REMARKS	
PERIODONTAL TREATMENT				
SHORTNESS OF BREATH				
LIP FEVER BLISTERS				LAST COMPLETE PHYSICAL EXAM DATE:
BREATH ODORS				ARE YOU UNDER A PHYSICIAN'S CARE?
TOOTH SENSITIVITY				MAY I CONSULT YOUR PHYSICIAN ABOUT YOU:
FOOD WEDGING BETWEEN TEETH				
TEETH STRAIGHTENED				
HEADACHES				DATE OF LAST COMPLETE DENTAL EXAM:
FAINTING SPELLS				FREQUENCY OF DENTAL EXAMS:
CHRONIC TIREDNESS				
CORTISONE				
BLOOD THINNER OR ASPIRIN				HOW OFTEN DO YOU CLEAN YOUR TEETH?
THYROID PROBLEM				
JOINT REPLACEMENT				WHAT TYPE OF BRUSH DO YOU USE?
MAJOR SURGERY				DO YOU FLOSS?
ALLERGIES				HOW OFTEN?
SINUS TROUBLE				
ANEMIA				
CARDIOVASCULAR DISEASE				
OSTEOPOROSIS / OSTEOPENIA				DO YOU HAVE ANY CONCERNS REGARDING THE
HEART MURMUR/PROLAPSE				APPEARANCE OF YOUR TEETH?
DIABETES				
HEPATITIS				
ARTHRITIS				CONCERNS ABOUT FUNCTION?
RHEUMATIC FEVER				
CLOTTING PROBLEMS				
KIDNEY PROBLEMS				
HIGH BLOOD PRESSURE				
LOW BLOOD PRESSURE				
EXCESSIVE THIRST				
LIVER TROUBLE				

DATE: ______________ **PATIENT SIGNATURE:** ______________________