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Diplomat- American Board of Periodontology PRACTICE LIMITED TO PERIODONTICS
University Periodontal Associates, Inc. (713) 523-9040

NAME:_____ HOME PHONE: _____

STREET ADDRESS:_____ CELL PHONE: _____

CITY, STATE:_____ ZIP:_____ E-MAIL: _____
DATE OF BIRTH:_____ SEX:_____ SSN#:_____

EMPLOYER:_____ WORK PHONE:_____
ADDRESS:_____ STE:_____ CITY, STATE, ZIP:_____

PERSON TO CONTACT IN CASE OF EMERGENCY:_____PHONE:_____
NAME OF INSURANCE CO.:_____ NAME OF INSURED:_____
INSURED D.O.B: _____ INSURED MEMBER ID#:_____
POLICY HOLDER'S EMPLOYER _____REFERRED BY:_____
_____ FAMILY DENTIST:_____PHYSICIAN:_____

LAST SEEN/REASON:_____

WHAT IS YOUR BIGGEST CONCERN ABOUT YOUR GUM, MOUTH OR TEETH?

WHEN WAS YOUR LAST VISIT TO YOUR FAMILY DENTIST, AND WHAT WAS THE NATURE OF YOUR VISIT?

HAVE YOU HAD PERIODONTAL TREATMENT BEFORE? (If so, when and where?)

HOW OFTEN DO YOU HAVE YOUR TEETH CLEANED, AND WHEN WERE THEY LAST CLEANED?

PLEASE CHECK ANY OF THE FOLLOWING IF YOU FEEL THEY APPLY TO YOU

[ ] Swollen or bleeding gums	[ ] Bad breath or mouth odors	[ ] Bad tastes
[ ] Painful gums or teeth	[ ] Sensitivity to hot or cold	[ ] Clenching of teeth
[ ] Loose teeth	[ ] Increasing spaces between your teeth	[ ] Other

HOW WOULD YOU FEEL IF YOU HAD TO LOSE YOUR TEETH?

ARE YOU ALLERGIC TO MINOCYCLINE OR IODINE? _____

OTHER ALLERGIES? _____

HAVE YOU HAD ANY SERIOUS ILLNESSES, OPERATIONS, OR HOSPITALIZATIONS IN THE PAST?____
_____

_____

HAS THERE BEEN A CHANGE IN YOUR HEALTH IN THE LAST TWO YEARS?_____

_____

_____

ARE YOU A "BLEEDER" FOLLOWING DENTAL TREATMENT?_____

_____

DO YOU SMOKE?_____ HOW MUCH?_____ HOW LONG?_____

DO YOU DRINK ALCOHOLIC BEVERAGES?_____

HAVE YOU HAD ANY OF THE FOLLOWING?

	YES	NO		YES	NO
HIGH BLOOD PRESSURE	[ ]	[ ]	DIABETES	[ ]	[ ]
PROLAPSED MITRAL VALVE	[ ]	[ ]	THYROID DISORDERS	[ ]	[ ]
RHEUMATIC FEVER	[ ]	[ ]	BLEEDING PROBLEMS	[ ]	[ ]
HEART PROBLEMS	[ ]	[ ]	BLOOD DISORDERS	[ ]	[ ]
ANGINA	[ ]	[ ]	ARTHRITIS	[ ]	[ ]
HEART ATTACK	[ ]	[ ]	JOINT IMPLANTS	[ ]	[ ]
HEART BYPASS SURGERY	[ ]	[ ]	NERVOUS DISORDERS	[ ]	[ ]
PACEMAKER	[ ]	[ ]	EPILEPSY	[ ]	[ ]
STROKE	[ ]	[ ]	HEADACHES	[ ]	[ ]
TUBERCULOSIS	[ ]	[ ]	STEROIDS	[ ]	[ ]
EMPHYSEMA	[ ]	[ ]	CANCER	[ ]	[ ]
ASTHMA	[ ]	[ ]	RADIATION	[ ]	[ ]
DIALYSIS	[ ]	[ ]	CHEMOTHERAPY	[ ]	[ ]
KIDNEY DISEASE	[ ]	[ ]	SLEEP APNEA	[ ]	[ ]

HEPATITIS/LIVER DISEASE [ ] [ ]

ARE YOU CURRENTLY:

PREGNANT [ ] [ ]

BREAST FEEDING [ ] [ ]

DO YOU HAVE ANY MEDICAL CONDITIONS NOT LISTED ABOVE THAT WE SHOULD KNOW ABOUT?

_____

WHAT IS YOUR HEIGHT?_____ WHAT IS YOUR WEIGHT?_____

HAVE YOU BEEN TREATED FOR ANY TYPE OF CHEMICAL DEPENDENCY?_____

PLEASE LIST ANY MEDICATIONS YOU ARE TAKING: PLEASE INCLUDE **ASPIRIN, VITAMINS, BIRTH CONTROL PILLS, AND ANY OTHER OVER THE COUNTER MEDICATIONS.**

DRUG DOSAGE HOW LONG?

_____

_____

_____

_____

NAME OF PHARMACY: _____PHONE #:_____

LOCATION:_____

CAN YOU TAKE IBUPROFEN? (ADVIL, NUPRIN)_____

ARE YOU TAKING OR HAVE YOU RECENTLY TAKEN DIET CONTROL MEDICATION? YES NO

PATIENT'S SIGNATURE_____ DATE_____

DOCTOR'S SIGNATURE_____ DATE_____