<u>David K. Dennison, D.D.S, M.S, Ph. D.</u>

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:
		PHONE:
NAME OF INSURANCE CO.:		NAME OF INSURED:
INSURED D.O.B:	INSURED MEMBER	R ID#:
POLICY HOLDER'S EMPLOYER		REFERRED BY:
FAMILY DENTIST:		PHYSICIAN:
LAST SEEN/REASON:		
WHAT IS YOUR BIGGEST CONCER	RN ABOUT YOUR GU	M, MOUTH OR TEETH?
WHEN WAS YOUR LAST VISIT TO	YOUR FAMILY DENT	IST, AND WHAT WAS THE NATURE OF YOUR VISIT
HAVE YOU HAD PERIODONTAL TI	REATMENT BEFORE?	(If so, when and where?)
HOW OFTEN DO YOU HAVE YOU	R TEETH CLEANED,	AND WHEN WERE THEY LAST CLEANED?
		IG IF YOU FEEL THEY APPLY TO YOU
[] Swollen or bleeding gums	[] Bad breath o	or mouth odors [] Bad tastes of or cold [] Clenching of teeth
[] Painful gums or teeth [] Sensitivity to ho	ot or cold [] Clenching of teeth
[] Loose teeth [] Increasing space	es between your teeth [] Other
HOW WOULD YOU FEEL IF YOU I	HAD TO LOSE YOUR	TEETH?
ARE YOU ALLERGIC TO MINOCY	CLINE 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" FOL	LOWING DE	NTA	L T	RI	EAT	ME	ENT?_		· -	
DO YOU SMOKE?DO YOU DRINK ALCOHOLIC	HOV BEVERAGES	V M	UCI	∃?				HOW LONG?	-	
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 []	[
I EMPHYSEMA	[]	[]			CANCER []	[
ASTHMA	[]	[]			RADIATION []	[
J DIALYSIS	[]	[]			CHEMOTHERAPY []	[
J KIDNEY DISEASE]	[]	[•]			SLEEP APNEA []	[

ARE YOU CURRENTLY PREGNANT ARE YOU CURRENTLY PREGNANT BREAST FEEDING TO 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. DOUG DOSAGE HOW LONG? WAME OF PHARMACY: DAME OF PHARMACY: DAME OF PHARMACY: DAME YOU TAKE IBUPROFEN? (ADVIL, NUPRIN) ARE YOU TAKING OR HAVE YOU RECENTLY TAKEN DIET CONTROL MEDICATION? PATIENT'S SIGNATURE DATE DOCTOR'S SIGNATURE DATE	LED	λТΙ	TIC	/I I\/ED C	ICEACE	F	1	гт			
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