

# University Periodontal Associates, Inc. 713-523-9040

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Diplomat- American Board of Periodontology

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: \_\_\_\_\_

DENTAL 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

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Swollen or bleeding gums | <input type="checkbox"/> Bad breath or mouth odors            | <input type="checkbox"/> Bad tastes         |
| <input type="checkbox"/> Painful gums or teeth    | <input type="checkbox"/> Sensitivity to hot or cold           | <input type="checkbox"/> Clenching of teeth |
| <input type="checkbox"/> Loose teeth              | <input type="checkbox"/> Increasing spaces between your teeth | <input type="checkbox"/> 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 ANYONE IN YOUR FAMILY EXPERIENCE COMPLICATIONS WITH SURGICAL/ANESTHESIA? \_\_\_\_\_

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	[ ]	[ ]	OSTEOPENIA	[ ]	[ ]
BLOOD THINNERS	[ ]	[ ]			
OSTEOPOROSIS	[ ]	[ ]	<b>ARE YOU CURRENTLY:</b>		
HIV/AIDS	[ ]	[ ]	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? \_\_\_\_\_

HAVE YOU OR ARE YOU TAKING ANY MEDICATIONS FOR OSTEOPOROSIS OR OSTEOPENIA? \_\_\_\_\_

**PLEASE LIST ANY MEDICATIONS YOU ARE TAKING: PLEASE INCLUDE ASPIRIN, BLOOD THINNERS, VITAMINS, BIRTH CONTROL PILLS, AND ANY OTHER OVER THE COUNTER MEDICATIONS. (ATTACH LIST IF NECESSARY)**

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 \_\_\_\_\_