MEDICAL HISTORY: Patient:_____

Primary Care Physician:_____ Phone: _____ Date of last medical exam:_____
Other Physician: _____ Phone: _____ Specialty:_____

How would you describe your present health? (circle one) GOOD FAIR POOR

Yes No

- ☐ ☐ Has there been any change in your general health in the past year?
- ☐ ☐ Have you had a serious illness, operation, or hospitalization in the past 5 years?
- ☐ ☐ Do you need to restrict your activity or work in any way, due to your current health?
- ☐ ☐ Have you ever had any prolonged or unusual bleeding following a dental procedure?
- ☐ ☐ Have you ever had any complications following dental treatment?
- ☐ ☐ Have you had any injury or trauma to your face or jaw?
- ☐ ☐ Have you ever had an adverse reaction to any dental anesthetics, sedatives, or drugs?
- ☐ ☐ Has your doctor told you to take antibiotics before a dental procedure? Do you need to be premedicated?
- ☐ ☐ Have you taken or do you take Aredia, Zometa, Fosamax or any other Bisphosphonates?
- ☐ ☐ Do you take any medications? Please list ALL medications as well as any OTC medications or supplements:

_____
_____

- ☐ ☐ Are you allergic to any of the following? If yes, please explain: _____

Aspirin Codeine Penicillin Latex Metal Anesthetic Other

- ☐ ☐ Do you smoke or use use smokeless tobacco now? Have you ever smoked? How many packs per day? _____
- ☐ ☐ Do you use any kind of alcohol? If so, how much: _____ per day, week, month
- ☐ ☐ Do you have any history of substance abuse or do you currently use recreational drugs?

Do you have, or have you had, any of the following? (please circle)

AIDS/HIV Positive	Chemotherapy/Radiation	Heart Attack	Mental Health Treatment
Alzheimer's Disease	Cold Sores/Fever Blisters	Heart Pacemaker	Mitral Valve Prolapse
Angina/Chest pains	Congenital Heart Disorder	Heart Disease	Neurological Disorders
Arthritis/Gout	Cough frequently	Hemophilia	Organ Transplant
Artificial Heart Valve	Diabetes type? _____	Hepatitis type? _____	Osteoporosis
Artificial Joint	Emphysema	High Blood Pressure	Rheumatic Fever
Asthma	Epilepsy or Seizures	Hives or Skin Rash	Sinus Trouble
Blood Disease	Esophageal Reflux	Kidney Problems	Sleep Apnea
Blood Transfusion	Fainting Spells/Dizziness	Leukemia	Stroke
Bruise Easily	Gastrointestinal Problems	Liver Disease	Thyroid Disease
Cancer type?_____	Glaucoma	Low Blood Pressure	Tuberculosis

Do you have any disease, problem or condition, not listed above? Please explain:_____
_____

WOMEN, check all that are appropriate: ☐ I am pregnant/trying to get pregnant ☐ I am taking birth control pills ☐ I am nursing

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____ _____
Signature of Patient, Parent, or Guardian Date:

perioindy
SARAH HERD, DDS, MSD

REGISTRATION:

Name: _____Name you prefer: _____ Sex: M / F

Birth Date: ____/____/____ SSN: _____-____-_____ Email: _____

Address: _____ City: _____ State: ____ Zip: _____

Best Phone #: ( ) _____ (Hm Wk Cell) Alternate Phone #: ( ) _____ (Hm Wk Cell)

Preferred Pharmacy and Location: _____Occupation:_____

General Dentist: _____ Referred by: _____

Emergency Contact: _____ Relationship: _____ Phone #: ( ) _____

INSURANCE:

Subscriber's Name: _____ Subscriber's Address: _____ Relationship to Patient: _____

Subscriber's SSN: _____-____-_____ Subscriber's DOB: ____/____/____

Employer: _____ ID #:_____ Group #:_____

Insurance Company: _____ Insurance Company Phone: ( ) _____

Insurance Address: _____ City: _____ State: ____ Zip: _____

Do you have Secondary Insurance? Yes No

Insurance eligibility and estimated benefits are based upon information we receive from you and your insurance company. Estimates are not a guarantee of insurance payment and final determination of benefits of is calculated at the time the insurance claim is processed. Regardless of estimated insurance coverage, I understand that any fee incurred will be my responsibility and I will keep my account current. I understand in signing this statement that I am financially responsible to Perio Indy for all fees incurred.

Signature: _____Date: _____

DENTAL HISTORY:

What is your main dental problem: _____

Describe any dental pain you have now: _____Date of last cleaning: _____

Circle any of the following you have now:

loose teeth	bleeding gums	food packing between teeth
missing teeth	puffy or sore gums	sensitive teeth
jaw clicking	discharge from gums	dry mouth
clenching/grinding habit	bad odor in mouth	burning tongue
pain in jaw joints	bad taste in mouth	

Have you had previous periodontal (gum) treatment? _____When: _____By Whom: _____

Have I treated any of your family or friends? _____ Who: _____