Virginia Perio
PERIODONTICS AND DENTAL IMPLANTS
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PATIENT INFORMATION (PLEASE PRINT)

Patient's Full Name _____ Age _____ Date of Birth _____ Sex _____
Address _____ County Of _____
City, State, and Zip Code _____ Social Security No. _____
Patient's Employer _____ Home Phone _____
Address _____ Cell Phone _____
Spouse's Name _____ Office Phone _____
Spouse's Employer _____ Email Address _____
Spouse's Work Address _____ Spouse's Work Phone No. _____
Whom may we contact in case of an emergency? _____ Phone No. _____
Who is financially responsible for this bill? _____
Address _____ Phone No. _____
Whom may we thank for referring you to us? _____

HAVE YOU HAD ANY OF THE FOLLOWING? (Please circle YES or NO)

Heart Murmur	YES	NO	Anemia	YES	NO
Rheumatic Fever	YES	NO	Asthma or Hay Fever	YES	NO
Diabetes	YES	NO	Epilepsy or Seizures	YES	NO
Heart Condition	YES	NO	Lung Disorders (T.B. or Emphysema)	YES	NO
Abnormal Blood Pressure	YES	NO	Thyroid Disorder	YES	NO
High Low			Arthritis	YES	NO
Bleeding Disorder	YES	NO	Glaucoma	YES	NO
Hepatitis	YES	NO	Psychiatric Treatment	YES	NO
Stomach Ulcers	YES	NO	HIV/Aids	YES	NO
Bleeding Gums	YES	NO	Do you use tobacco?	YES	NO
Jaundice or Liver Disorder	YES	NO			

Are you presently under the care of a physician? YES NO Explain _____
Have you ever had any serious illness or operation? YES NO Explain if yes _____
Are you allergic to any foods or medications? YES NO Explain _____
Has anyone in your family had diabetes? YES NO
If female, are you pregnant at this time? YES NO If so, which month? _____
Are you taking any medication now? YES NO For what purpose? _____
Have you ever taken or are you taking:

Cortisone	YES	NO	Anticoagulants (blood thinners)	YES	NO
Tranquilizers	YES	NO	Nitroglycerine	YES	NO
Digitalis	YES	NO	Oral Contraceptives or Hormones	YES	NO

When was the last time you were treated by your dentist? _____
What was done at the time? _____
Have you ever had any complications associated with previous dental treatment? _____
Explain _____
Do you have any condition in your mouth that is causing you discomfort or concern? _____

I fully understand that I am financially responsible for all fees not covered by my insurance company.

Date: _____ Patient's Signature: _____

Parent's signature if patient is a minor: _____