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BROWARD CENTER FOR PERIODONTICS, IMPLANTS & LASER TREATMENTS

WELCOME

TODAYS DATE:_____ □ **Single** □ **Married** □ **Divorced** □ **Widowed** □ **Separated**

About You

☐Male☐Female

Name: _____
Last First MI (Mr. Ms. Mrs. Dr.)

Home #: _____ **Cell#**_____ **Work#**_____

Birthdate:_____ **Age:** _____ **Social Sec#:** _____

Home Address: _____

_____

Email: _____

Employer: _____

Phone #: _____

Current Dentist: _____ **PH:** _____

Whom May We Thank for Referring You? _____

Person Responsible for Account

Name: _____

Address:_____

Relationship:_____

Phone:_____

Spouse Information

Name:_____

Home#:_____ **Cell:** _____

Employer: _____

Work#: _____

Birthday: _____

Dental Insurance

Insured's Name: _____

Relation: _____

Insurance Co. Name: _____

Insurance Co. PH#: _____

Group Policy# _____**Group#** _____

Insured's Social Sec#: _____

Insured's Birthday: _____

Insured's ID: _____

What is your primary concern about your mouth?

_____

Do you smoke? Yes/ No

Are you currently in pain? Yes / No

Do you now or have you ever experienced pain/discomfort in your jaw Joint (TMJ)? Yes/ No

Do your gums bleed? Yes/ No

Do you have a water pik? Yes/ No Do you use it? Yes/ No

Have you ever been examined specifically for periodontal disease? If yes by whom? Dr. _____

Do you frequently eat sweets, use mints, or gum? Yes/No

How severe do you consider your gum problem?

☐ **Minimal** ☐ **Moderate** ☐ **Severe**

Does the appearance of your teeth bother you? Yes/ No

Have you ever had a serious or difficult problem associated with any previous dental work? Yes/No If yes, what did you have done?

_____

Do you use anything to clean between your teeth? Yes / No If yes, what? _____

When were your teeth last cleaned by a dentist? _____

Are you nervous about dental visits? Yes/No

Are you bothered by persistent bad breathe or bad taste in your mouth? Yes/ No

What other information would help us serve you better?

_____

_____

MEDICAL HISTORY

How would you describe your health?
☐ **Excellent** ☐ **Good** ☐ **Fair** ☐ **Poor**

Have you ever been hospitalized?
Yes/No If yes, what for?
_____

Are you currently under the care of a Physician? Yes/No **Pharmacy #:** _____

If yes, please explain: _____
Physician's Name: _____
Work #: _____

Do you need to Pre-Med before dental visits? Y/N
If yes, what for? _____
What medication do you take? _____

Please list any medications that you are taking Including *ASPIRIN* & *PLAVIX:*

_____

Are you Allergic to any of the following drugs?

Y/N Penicillin Y/N Codeine Y/N Erythromycin
Y/N Tetracycline Y/N Aspirin Y/N Latex
Y/N Barbituates Y/N Sleeping Pills Y/N Dental Anesthetics
Y/N Sedatives Other Allergies: _____

Are you taking birth control pills? Yes/No

Are you pregnant? Yes/No

Have you ever had any of the following? Please check and circle:

- ☐ **Heart Attack / Stroke**
- ☐ **Psychiatric Problems**
- ☐ **Rheumatic Fever**
- ☐ **Drug/Alcohol Abuse**
- ☐ **Cancer/Chemotherapy**
- ☐ **Heart Murmur**
- ☐ **Mitral Valve Prolapse**
- ☐ **Diabetes/Tuberculosis (TB)**
- ☐ **HIV+/AIDS**
- ☐ **Venereal Disease**
- ☐ **Hemophilia/Abnormal Bleeding**
- ☐ **Osteoporosis/Meds for?**
- ☐ **Ulcers/Colitis**
- ☐ **Thyroid problems**
- ☐ **Congenital Heart Defect**
- ☐ **Kidney Problems**
- ☐ **Anemia/Radiation Treatment**
- ☐ **Heart Surgery/Pacemaker**
- ☐ **Epilepsy/Seizure/Fainting Spells**
- ☐ **Asthma/Arthritis**
- ☐ **Difficulty Breathing**
- ☐ **Artificial Bones/Joints**
- ☐ **Artificial Valves/Stent**
- ☐ **Sinus Problems/Allergies**
- ☐ **High/low Blood Pressure**
- ☐ **Fever Blisters/Shingles**
- ☐ **Severe/Frequent Headaches**
- ☐ **Hepatitis**
- ☐ **Blood Transfusion**
- ☐ **Ephysema/Glaucoma**

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Signature **Date:**

OFFICE USE ONLY **Medical History Update**

I VERBALLY REVIEWED THE MEDICAL/ DENTAL INFORMATION ABOVE WITH THE PATIENT NAMED HEREIN: Initials Date

1. Date _____ Comments _____ Signature _____
2. Date _____ Comments _____ Signature _____
3. Date _____ Comments _____ Signature _____