Bellaire Periodontics

PATIENT INFORMATION

Date: ☐NEW PATIENT ☐UPDATE

Patient:

LAST FIRST MI PREFERRED TITLE

☐MALE ☐FEMALE ☐CHILD* ☐STUDENT** ☐SINGLE ☐MARRIED ☐DIVORCED ☐WIDOWED

*IF CHILD, PROVIDE PARENT/GUARDIAN NAME(S) BELOW:

PARENT/GUARDIAN NAME(S)

**IF STUDENT, PLEASE COMPLETE: ☐FULL-TIME ☐PART-TIME

SCHOOL/LOCATION

Patient Date of Birth: Patient SSN:

Address:

ADDRESS LINE 1

ADDRESS LINE 2

CITY ST ZIP CODE

E-Mail:

HOME:
CELL:
OTHER:
PAGER:
FAX:

Referral? ☐Yes ☐ No Referred by:

EMERGENCY INFORMATION

In case of emergency, please provide information for the nearest relative or designated contact person not at the patient's address:

NAME RELATIONSHIP

Tel:

EMPLOYMENT INFORMATION

Employer: Occupation:

Address:

ADDRESS LINE 1

ADDRESS LINE 2

CITY ST ZIP CODE

E-Mail:

WORK:
DIRECT:
OTHER:
PAGER:
FAX:

INSURANCE INFORMATION

Subscriber:

LAST FIRST MI PREFERRED TITLE

Subscriber Date of Birth: Subscriber SSN:

Subscriber Employer:

Patient Relationship to Subscriber: ☐SELF ☐SPOUSE ☐CHILD ☐OTHER

PRIMARY INSURANCE CARRIER:

Group/Policy No.: ID No.:

Address:

CITY ST ZIP CODE

TEL:
TOLL-FREE:
FAX:

SECONDARY INSURANCE CARRIER:

Group/Policy No.: ID No.:

Address:

CITY ST ZIP CODE

TEL:
TOLL-FREE:
FAX:

REFERRING DENTIST INFORMATION

Dentist: _____ Telephone: _____

Clinic/Facility: _____

Address: _____

_____

CITY ST ZIP CODE

Reason for changing: _____

MEDICAL HISTORY

GENERAL HEALTH: ☐EXCELLENT ☐GOOD ☐FAIR ☐POOR

☐Y☐N Under a physician's care now?
☐Y☐N Any hospitalization in the past 5 years? _____
☐Y☐N Any serious illnesses/surgeries? _____
☐Y☐N Are you on a special diet? _____
☐Y☐N Use tobacco in any form? If Yes, Type: _____
☐Y☐N Is pre-medication required before dental visits due to heart condition or artificial joint?
☐Y☐N Do you take, or have you taken, Phen-Fen or Redux?
☐Y☐N Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?
☐Y☐N Taking any prescription or daily OTC medications/drugs? *If yes, list details in the Medication Section.*

FEMALE PATIENTS: ☐Y☐N Currently nursing? ☐Y☐N Currently pregnant? Due Date: _____

Trying to get pregnant? ☐Y☐N Taking oral contraceptives? ☐Y☐N

_____

Is there anything important about your medical condition we have not asked? ☐Y☐N If yes, please describe:

_____

ALL PATIENTS: DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): ☐NONE

☐ACID REFLUX	☐BULIMIA	☐HEARING PROBLEMS	☐PSYCHIATRIC TREATMENT
☐ADHD	☐CANCER/MALIGNANCY	☐HEART ATTACK	☐RADIATION/CHEMO
☐AIDS/HIV	☐CEREBRAL PALSY	☐HEART DISEASE	☐RESPIRATORY DISEASE
☐ANEMIA	☐CHEMICAL DEPENDENCY	☐HEART MURMUR	☐RHEUMATIC FEVER
☐ANOREXIA	☐CHICKEN POX	☐HEPATITIS	☐SINUS PROBLEMS
☐ANXIETY	☐CONVULSIONS	☐HIGH BLOOD PRESSURE	☐STROKE
☐ARTIFICIAL HEART VALVE	☐DEPRESSION	☐KIDNEY DISEASE	☐THYROID CONDITION
☐ARTIFICIAL JOINTS	☐DIABETES	☐LIVER PROBLEMS	☐TUBERCULOSIS
☐ARTHRITIS	☐DIZZINESS/FAINTING	☐MITRAL VALVE PROLAPSE	☐ULCERS
☐ASTHMA	☐EPILEPSY/SEIZURES	☐MONONUCLEOSIS	☐VENEREAL DISEASE
☐AUTISM/ASPERGER'S	☐FREQUENT EAR INFECTIONS	☐PACEMAKER	
☐BLEEDING DISORDER	☐ FREQUENT HEADACHES	☐OTHER – PLEASE LIST: _____	

MEDICATION INFORMATION

ALL PATIENTS: ARE YOU CURRENTLY TAKING ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): ☐NONE

☐ANTIBIOTICS/SULFA DRUGS	☐ANTIHISTAMINES/ALLERGY	☐DAILY ASPIRIN	☐BLOOD PRESSURE MEDICATIONS
☐BLOOD THINNERS	☐CANCER/CHEMO MEDICATIONS	☐CORTISONE/STEROIDS	☐HEART MEDICATION/DIGITALIS
☐INSULIN	☐NITROGLYCERIN	☐ORAL CONTRACEPTIVES	☐OSTEOPOROSIS MEDICATIONS
☐OTHER DIABETIC MEDICATIONS	☐RECREATIONAL DRUGS	☐THYROID MEDICATIONS	☐TRANQUILIZERS

☐OTHER (PLEASE LIST BELOW)

DRUG NAME	DOSAGE	REASON PRESCRIBED

ALL PATIENTS: ARE YOU ALLERGIC TO OR HAVE YOU EVER HAD ANY REACTION TO THE FOLLOWING? (CHECK ALL THAT APPLY):

☐ ASPIRIN	☐ CODEINE	☐ LOCAL ANESTHETICS	☐ ACRYLIC	☐ NONE
☐ ANESTHETIC – LOCAL	☐ DAIRY	☐ METAL SENSITIVITY	☐ SULFA DRUGS	
☐ BARBITURATES	☐ LATEX	☐ NITROUS OXIDE SEDATION	☐ PENICILLIN/OTHER ANTIBIOTICS	
☐ OTHER – PLEASE LIST:				

By signing below, I certify that the information above is accurate and complete to the best of my knowledge.

Signature:_____ **Date:** _____