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PRACTICE LIMINTED TO PERIODONTICS WITH SERVICES IN DENTAL IMPLANTS

Child (Dependent) Examination and Health History

Since periodontal disease is caused by a combination of complex factors, it is necessary to resolve every possible contributing factor. The success of therapy is most dependent upon this. Although some of the questions may seem unrelated to your periodontal condition, they are associated with the proper management of your physical and oral health.

Today's Date: _____ Date of Birth: _____

Patient's Name: _____
(First) (Middle) (Last)

Name Preferred: _____ Home Phone: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Patients Height: _____ Patient's Weight: _____

Mother's Name: _____ Father's Name: _____

Date of Birth: _____ Date of Birth: _____

Home Address: _____ Home Address: _____
_____ _____

Cell Phone: _____ Cell Phone: _____

Employed By: _____ Employed By: _____

Office Phone: _____ Office Phone: _____

Dental Insurance Co. _____ Dental Insurance Co. _____

Social Security No.: _____-_____-_____ Social Security No.: _____-_____-_____

Who referred you to our office? _____

PLEASE INDICATE YES OR NO FOR THE FOLLOWING QUESTIONS:

Are you aware of being allergic to or have you ever reacted adversely to any medication or substance __Y __N
If yes, please list_____
_____
Are you currently under the care of a physician?
If yes, please list condition _____
Physician's Name: _____ Phone No.:_____
Are you currently taking any prescription medicines? __Y __N
If yes, please list_____
_____
Are you currently taking any over the counter, herbal medicines or vitamin supplements? __Y __N
If yes, please list_____
_____
Have you had major surgery or been hospitalized in the last 5 years? __Y __N
If yes, please list_____
_____
Have you ever had excessive bleeding requiring special treatment? __Y __N
Do you take aspirin on a daily basis? __Y __N
Do you take blood thinners? __Y __N
Do you require pre-medication with antibiotics prior to dental treatment? __Y __N
If yes, for what condition? _____
Do you use tobacco products __ Cigarettes? __ Snuff/Chewing tobacco?

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING CONDITIONS?

Heart murmur/MVP __Y __N
Heart valve replacement __Y __N
Heart Problems __Y __N
High Blood Pressure __Y __N
Blood or Clotting Disorders __Y __N
Stroke __Y __N
H.I.V. Positive/A.I.D.S. __Y __N
Hepatitis A, B, OR C __Y __N
(Indicate type)
Diabetes (Type I or II) __ Y __N
Kidney Disorder __ Y __N
Tuberculosis __Y __N
Stomach Ulcer __Y __N
Reflux Disease __Y __N

Tumor/Cancer __Y __N
Type_____
Chemotherapy __Y __N
Radiation Therapy __Y __N
Arthritis __Y __N
Artificial Joints
Date of Placement_____
Tendency to faint __Y __N
Epilepsy/Seizures __Y __N
Anemia __Y __N
Do you bruise easily? __Y __N
Asthma/Hay Fever __Y __N
Hyper or Hypothyroidism __Y __N