

DR. MICHAEL M. PERRY • DR. BRENDA L. FOWLER

Periodontal Plastic Surgery-Regenerative Therapy-Dental Implants

PATIENT'S NAME _____ Social Security No. _____ Date _____
Home Address _____ City _____ State _____ Zip _____ Res. Tel. _____
Cell Phone _____ Date of Birth _____ Age _____ Height _____ Weight _____ Marital Status _____
Occupation _____ Employer _____ Bus. Tel. _____
Business Address _____ City _____ State _____ Zip _____
Spouse's Name _____ Social Security No. _____ Bus. Tel. _____ Spouse's Occupation _____
Employer _____ PERSON TO CONTACT IN AN EMERGENCY _____ Tel. _____
PARTY RESPONSIBLE FOR PAYMENT _____ Bus. Tel. _____ Res. Tel. _____
METHOD OF PAYMENT: _____ Visa _____ MC _____ Discover _____ Check _____ Cash

IF YOU HAVE DENTAL INSURANCE, PLEASE COMPLETE THE FOLLOWING:

Dental Insurance Co. _____ Address _____ Name of Insured _____
Social Security No. _____ D.O.B. _____ Policy No. _____ Group Number _____
Whom may we thank for referring you? _____ Reason for this visit _____

HEALTH HISTORY

For your safety and to assist us in accurately diagnosing and treating you, please carefully review this form completely and fill out **all** areas, which pertain to you.

DENTAL HISTORY:

Your Dentist _____ City _____ How Long _____ Last Visit _____ Date of Last Cleaning _____
Last Full Mouth X-Rays _____

Check any of the following you have had or currently have:

<input type="checkbox"/> Mouth Discomfort	<input type="checkbox"/> Grinding or Clenching Your Teeth	<input type="checkbox"/> Had Immediate Relatives Lose All Of Their Natural Teeth
<input type="checkbox"/> Previous Periodontal Treatment <input type="checkbox"/> Scaling/Root Planing <input type="checkbox"/> Gum Surgery	<input type="checkbox"/> Clicking, Popping or Pain in Jaw Joints	<input type="checkbox"/> Orthodontic Treatment
<input type="checkbox"/> Bad Dental Experience	<input type="checkbox"/> Gum Abscesses	<input type="checkbox"/> Sensitive Teeth (Hot, Cold or Sweets)
<input type="checkbox"/> Complications with or following Dental or Surgical Treatment	<input type="checkbox"/> Cold Sores or Fever Blisters	<input type="checkbox"/> Mouth Odor or Bad Taste
<input type="checkbox"/> Gums Bleed when Brushing	<input type="checkbox"/> Awake with Sore Jaw	<input type="checkbox"/> Bruise Easily
<input type="checkbox"/> Fear of Dental Treatment	<input type="checkbox"/> Trouble in Chewing or Speaking	<input type="checkbox"/> Other Oral Lesions

Do you want to keep your teeth? Yes, no matter what it takes Don't know
 Yes, if it's not too much trouble Don't care

MEDICAL HISTORY:

1. Name of Physician _____ Date of last visit _____ Purpose _____

Findings _____ How would you describe your health? Excellent Good Fair Poor

**Please continue on the reverse side*

2. Are you aware of any changes in your general health in the last year? NO YES _____

3. Have you been hospitalized for illness or surgery in the past five years? NO YES _____

4. Have you been under a medical doctor's care during the past two years? NO YES _____

5. Have you ever had excessive bleeding that required special treatment? NO YES _____

6. Is there any history of diabetes in your family? NO YES _____

7. Are you required to restrict your work activity in any way? NO YES _____

8. DO YOU SMOKE? NO YES How much? _____ How Long? _____

9. List ALL medications you are now taking and their purpose (include all over the counter drugs, vitamins, and previous use of Fen-Phen)

10. Have you ever taken **Fosomax, Aredia, Actenol, Zometa, or any other bisphosphonate**? If so, which one and how long? _____

PLEASE CIRCLE ANY OF THE FOLLOWING MEDICATIONS YOU ARE ALLERGIC TO:

Penicillin	Doxycycline	Novocaine	Codeine	Valium	Aspirin	Vicodin
Erythromycin	Sulfa Drugs	Carbocaine	Demerol	Versed	Tylenol	Lortab
Tetracycline	Keflex	Xylocaine	Nubain	Halcion	Ibuprofen	Latex
Darvocet	Others _____					

PLEASE CIRCLE ANY OF THE FOLLOWING THAT YOU NOW HAVE OR HAVE EVER HAD:

Heart Trouble	Ankles Swell	Diabetes	Psychiatric Care
Heart Attack or Disease	Anemia	Frequent Thirst/Urination	Ulcers
Angina or Chest Pain	Sickle Cell Disease	Stroke	Contact Lenses
High Blood Pressure	Artificial Knee	Epilepsy or Seizures	Hepatitis
Low Blood Pressure	Artificial Hip	Frequent Headaches	Liver Disease
Heart Murmur	Kidney/Bladder Trouble	Fainting or Dizzy Spells	AIDS/ HIV
Rheumatic Fever	Emphysema	Cancer or Tumors	Hemophilia
Congenital Heart Lesions	Thyroid Disease	Asthma	
Blood Transfusion	Radiation Treatment	Artificial Heart Valve	Chemotherapy
Unintentional Weight Gain/Loss	Scarlet Fever	Sinus Trouble	Glaucoma
Arthritis/Rheumatism	Shortness of breath	Allergies	
None of the Above			

If Female, are you? _____ Pregnant _____ Nursing _____ Taking birth control pills _____ Taking hormone medication _____

Do you have any medical condition / disease not listed above that we should know about? NO YES _____

CONSENT

The undersigned hereby authorizes the doctor or staff to take x-rays, study models, photographs or any diagnostic aids deemed appropriate to make a thorough diagnosis. All responsibilities for dental services provided in this office for myself or my dependent is totally mine, due and payable at the time of service unless a previous financial arrangement has been made.

I certify that all the above questions were answered truthfully and to the best of my knowledge with the understanding that they were necessary to provide quality dental care in a safe and efficient manner.

Patient's Signature _____ **Dentist's Signature** _____