PERRY PLAZA DENTAL

Patient Information

General Information

First Name _____ Last Name _____ Middle Initial_____
Preferred Name_____ Date of Birth _____
Mobile Phone _____Work Phone _____Home Phone _____
Address 1 _____ Address 2_____
City _____ State_____ Zip_____
Email Address _____ Sex: o Male o Female
Employer _____
Preferred Method of Communication: o Phone o Text o Email

Previous Dentist _____Last Dentist Visit_____
Preferred Pharmacy_____ # (if known) _____

Responsible Party / Primary Insurance Policy Holder
If Policy Holder is the Patient you only need to fill in patient's Social Security Number

Relationship to Insured o Self o Spouse o Child o Other
Employer _____
Birthdate _____ Social Security # _____
First Name_____ Last Name_____
Address 1 _____Address 2 _____
City_____ State _____ Zip _____
Mobile Phone _____Work Phone _____Home Phone _____

In Case of Emergency
Emergency Contact Name_____ Emergency Contact # _____
Relationship_____

Referred by: _____

Music

Please let us know your music preferences below so we may accommodate you during your appointment.

Jazz	Rock	Country	R&B	Pop	Christian	Indie Music
80's	Classical	Classic Rock	Relaxation	Top 40	Rap	Alternative

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Medical History

Your oral health is connected to the health of your entire body. It's important for us to know your medical history because health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dental treatment you receive.

Medical History

Are you under a physician's care now? o Yes o No
If yes, please explain: _____

Have you ever been hospitalized or had a major surgery? o Yes o No
If yes, please explain: _____

Are you taking any medications, pills, or drugs? o Yes o No
If yes, please explain: _____

Do you take, or have you ever taken, Phen-Fen or Redux? o Yes o No
If yes, please explain _____

Have you taken Fosamax, Boniva, Actonel or any other Bisphosphonate drugs? o Yes o No
If yes, please explain: _____

Are you on a special diet? o Yes o No

Do you use tobacco of any kind? o Yes o No

Women, are you….

o Pregnant or Trying to Get Pregnant? o Taking Oral Contraceptives? o Nursing?

Are you allergic to any of the following?

o Aspirin o Penicillin o Codeine o Acrylic
o Metal o Latex o Sulfa Drugs o Local Anesthetics
o Other If yes _____

Do you use controlled substances? o Yes o No If yes_____
Do you have , or have you had, any of the following? Please circle all those that apply.

AIDS/HIV	Cortisone Medicine	Hemophilia	Radiation Treatments
Alzheimer's Disease	Diabetes	Hepatitis A	Recent Weight Loss
Anaphylaxis	Drug Addiction	Hepatitis B or C	Renal Dialysis
Anemia	Easily Winded	Herpes	Rheumatic Fever
Angina	Emphysema	High Blood Pressure	Rheumatism
Arthritis/Gout	Epilepsy or Seizures	High Cholesterol	Scarlet Fever
Artificial Heart Valve	Excessive Bleeding	Hives or Rash	Shingles
Artificial Joint	Excessive Thirst	Hypoglycemia	Sickle Cell Diseases
Asthma	Fainting Spells/Dizziness	Irregular Heart Beat	Sinus Trouble
Blood Disease	Frequent Cough	Kidney Problems	Spina Bifida
Blood Transfusion	Frequent Diarrhea	Leukemia	Stomach/Intestinal Disease
Breathing Problems	Frequent Headaches	Liver Disease	Stroke
Bruise Easily	Genital Herpes	Low Blood Pressure	Swelling of Limbs
Cancer	Glaucoma	Lung Disease	Thyroid Disease
Chemotherapy	Hay Fever	Mitral Valve Prolapse	Tonsillitis
Chest Pains	Heart Attack/Failure	Osteoporosis	Tuberculosis
Cold Sores/Fever Blisters	Heart Murmur	Pain in Jaw Joints	Tumors or Growths
Congenital Heart Disorder	Heart Pacemaker	Parathyroid Disease	Ulcers
Convulsions	Heart Troubles/Diseases	Psychiatric Care	Venereal Disease
			Yellow Jaundice

Have you ever had any serious illnesses not listed? o Yes o No

If yes, please explain: _____

To the best of my knowledge, the above medical history questions have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform Perry Plaza Dental of any changes in medical status.

Signed_____
Date _____