Dental Implant & Periodontal Partners, LLP

Stephen L. Bass, DDS, MS, PA • Ellen Hall, DDS, MS, PA Date _____

Patient's Name _____ SSN _____ E-Mail _____

Home Address _____ Apt# _____ City _____ Zip _____ Home Phone _____

Date of Birth _____ Age_____ Height _____ Weight _____ Cell Phone_____

Marital Status ___Gender ___Parent or Emergency Contact _____ Phone _____

Occupation _____ Employer _____ Bus. Phone _____

Insured's Name _____ SSN _____ Date of Birth _____

Insured's Occupation _____ Employer _____ Bus. Phone _____

Insurance Company _____ ID Number _____

Referred By _____ Reason for Referral _____

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 that pertain to you.

Name of Physician_____ Phone Number _____ Last Visit _____

Are there any changes in your health in the last year? No Yes _____

Have you been hospitalized in the past 5 years? No Yes _____

Have you been under a physician's care in the last 2 years? No Yes _____

Do you smoke? No Yes Packs/Day? _____ Number of Years? _____

Please list ALL medications you are now taking (include over the counter drugs and vitamins): _____

_____

Do you premedicate with antibiotics prior to dental procedures? No Yes _____

Please circle any of the following medications you are ALLERGIC to:

Penicillin	Doxycycline	Codeine	Valium	Aspirin	Latex
Erythromycin	Tetracycline	Demerol	Versed	Tylenol	Dental Anesthetics
Keflex	Sulfa Drugs	Hydrocodone	Halcion	Ibuprofen	

Any Others _____

Please circle any of the following that you now have or have ever had:

Heart Trouble	Ankles Swell	Stroke	ADHD/ADD
Heart Attack	Anemia	Epilepsy or Seizures	Depression
Angina/Chest Pain	Sickle Cell Disease	Frequent Headaches	Ulcers
Low/High Blood Pressure	Artificial Knee/Hip Joint	Kidney/Bladder Trouble	Hepatitis
Heart Murmur	Fainting/Dizziness	Cancer or Tumors	Liver Disease
Rheumatic Fever	Emphysema/COPD	Radiation Treatment	AIDS/HIV
Congential Heart Lesions	Thyroid Disease	Chemotherapy	Blood Thinner
Artificial Heart Valve	Asthma	Arthritis/Rheumatism	Blood Transfusion
Sinus Trouble	Seasonal Allergies	Osteoporosis	Hemophilia
Shortness of Breath	Diabetes	Osteopenia	Unintentional Weight Loss/Gain
	Frequent Thirst/Urination	Glaucoma	Recreational/Illegal Drug Use

If Female, are you: Pregnant _____ Nursing ____ Taking Birth Control Pills ____ Taking Hormones _____

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

Have you taken any bone sparing drugs? (Actonel, Fosamax, Boniva, Zometa, Aredia) No Yes

_____

Dental History

Your Dentist _____ City _____ How Long? _____

Date of Last Cleaning _____ Frequency of Cleanings? _____

How often do you brush your teeth daily? _____ Manual or Mechanical Brush Do you floss daily? Yes No

Please check if you currently have or have had:

___ Mouth Discomfort
___ Previous Periodontal Treatment
___ Scaling/Root Planing
___ Gum Surgery
___ Gum Abscesses
___ Bleeding Gums
___ Loose or Shifting Teeth
___ Bruise Easily

___ Grinding or Clenching Your Teeth
___ Clicking, Popping or Pain in the Joints
___ Orthodontic Treatment
___ Sensitive Teeth (Hot, Cold, or Sweets)
___ Mouth Odor or Bad Taste
___ Cold Sores or Fever Blisters
___ Other Oral Lesions/Sores

___ Have Immediate Relatives Lost All Natural Teeth
___ Bad Dental Experience
___ Fear of Dental Treatment
___ Complications following Dental Treatment

Do You Want to Keep Your Teeth? ___ Yes, no matter what it takes ___ Don't know
___ Yes, if it is not too much trouble ___ Don't care

Are You Happy with Your Smile? ___ Yes ___ No

If not, what would you change? _____

CONSENT

I attest that to the best of my knowledge, the information provided is accurate and complete. Any changes in health status or medications will be reported to the Doctor. I authorize the Doctor or his representatives to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate to make a through diagnosis and to develop proper treatment recommendations. I also authorize the Doctor to perform any and all forms of treatment, medication, and therapy indicated after all my questions have been answered. Scheduling an appointment is interpreted as authorization for treatment. I also understand that the use of anesthetic agents embody certain risks. Responsibility for payment of dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made in advance. I also acknowledge that I have received a copy of the office's Notice of Privacy Practices either in written form or from the website www.implantperioteam.com.

Signature: _____ Date: _____

☐ Patient ☐ Parent ☐ Guardian

Doctor's Signature: _____