PARTRIDGE PERIODONTICS

PERIODONTOLOGY, ORAL PLASTIC SURGERY, and IMPLANTOLOGY

LAST NAME | FIRST NAME | BIRTHDATE Mo Day Yr | HEIGHT | WEIGHT | MARITAL STATUS

RESIDENCE ADDRESS | CITY | STATE | ZIP | RESIDENCE TELEPHONE

EMPLOYER (Patient/Parent) | BUSINESS ADDRESS | OCCUPATION | BUSINESS TELEPHONE

NAME OF HUSBAND, WIFE OR PARENT | DENTAL INSURANCE CARRIER | PERSON RESPONSIBLE FOR ACCOUNT

REFERRED BY | SOCIAL SECURITY # | NAME OF PHYSICIAN | TELEPHONE

GENERAL	**Circle One**
1) Has there been any change in your general health during the last year?	Yes No DK*
2) Have you been examined by your physician within the last year?	Yes No DK
3) Are you receiving any treatment by any doctor now?	Yes No DK
4) Are you taking any medicines now, including over-the-counter medicines?	Yes No DK
5) Has a dentist or physician ever told you that you had a tumor or cancer?	Yes No DK
6) Have you ever had rheumatic fever?	Yes No DK
7) Have you ever had excessive bleeding following extraction of teeth or from a cut?	Yes No DK
8) Are you sensitive to any particular medicine (Aspirin - Penicillin - Novocaine)?	Yes No DK
9) Have you ever been treated for eye trouble such as glaucoma?	Yes No DK
CARDIOVASCULAR	
10) Has a physician ever said you had heart trouble?	Yes No DK
11) Have you ever had a heart murmur or mitral valve prolapse?	Yes No DK
12) Have you ever had a heart attack?	Yes No DK
13) Has a physician ever said your blood pressure was too high or too low?	Yes No DK
14) Have you ever been told you need to take antibiotics prior to dental treatment?	Yes No DK
GASTRO-INTESTINAL	
15) Do you suffer from stomach, intestinal, or colon trouble?	Yes No DK
16) Have you ever had liver trouble?	Yes No DK
RESPIRATORY	
17) Do you smoke?	Yes No DK
18) Do you have asthma?	Yes No DK
19) Have you ever been tested for tuberculosis?	Yes No DK

GENITO-URINARY	**Circle One**
20) Did a physician ever say that you had kidney or bladder trouble?	Yes No DK
21) Have you been tested for HIV (Aids)?	Yes No DK
FEMALE	
22) Are you pregnant or planning a pregnancy?	Yes No DK
23) Are you using hormone replacement or do you take birth control pills?	Yes No DK
ENDOCRINE SYSTEM	
24) Have you or has a family member ever been diagnosed with diabetes?	Yes No DK
NERVOUS SYSTEM	
25) Have you ever had a stroke?	Yes No DK
26) Are you under a lot of unusual stress?	Yes No DK
SKIN	
27) Have you ever had hives or skin rash or skin disease?	Yes No DK
BONES AND JOINTS	
28) Do you have arthritis or rheumatism?	Yes No DK
29) Do you have a history of back or joint problems?	Yes No DK
30) Have you had any joint replacement?	Yes No DK
DENTAL	
31) Do your gums bleed when you brush your teeth?	Yes No DK
32) Have you ever had gum treatments?	Yes No DK
33) Do you grind or clench your teeth when you are nervous or while sleeping?	Yes No DK
34) Do you feel that an attempt to save your teeth is a waste of time?	Yes No DK
35) Is there any dental or medical condition you have that you feel could affect your treatment at this office?	Yes No DK

Patient/Parent Signature _____ Date: _____

Chief Complaint: _____

Medical Summary: ☐ NON CONTRIBUTORY ☐ SIGNIFICANT

Current Medications: _____

*Don't Know

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