AUBURN
PERIODONTICS & IMPLANTOLOGY

Patient Information

Patient's Name _____ Date of Birth ___/___/____ Referred by _____

Address _____ City _____ Zip _____

Home Phone _____ Cell Phone _____ E-mail _____

Marital Status _____ Employer _____ Work Phone _____

Spouse's Name _____ Date of Birth ___/___/_____ Employer _____

Dentist _____ Physician _____

Dental Insurance

Primary Dental Insurance Company _____

S.S.N. _____-_____-_____ Group No. _____ Date of Birth _____/_____/_____

Secondary Dental Insurance Company _____

S.S.N. _____-_____-_____ Group No. _____ Date of Birth ____/____/_____

Medical History

General Information	Yes	No	?
1. Has there been any change in your general health in the past 12 months?			
2. Are you receiving any treatment by any doctor right now?			
3. Are you taking any medications? Please list:			
4. Have you ever had an operation? If so, when?			
5. Have you ever had a serious illness?			
6. Has a dentist or physician ever told you that you had a tumor or cancer?			
7. Have you ever had rheumatic fever?			
8. Have you ever had excessive bleeding following the extraction of teeth or a cut?			
9. Are you sensitive or allergic to any particular medication? Please list on next page			
10. Do you suffer from frequent severe headaches?			
11. Have you had a recent change in your appetite, bowel habits or sleep pattern?			
12. Do you have any artificial heart valves or joints?			
13. Do you require antibiotics prior to any dental treatment?			

Cardiovascular	Yes	No	?
14. Has a physician ever said you had heart trouble?			
15. Have you ever had rheumatic heart disease?			
16. Has a physician ever said your blood pressure was either too high or too low?			

Gastrointestinal	Yes	No	?
17. Has a physician ever told you that you had ulcers?			
18. Have you ever been jaundiced (Hepatitis)?			

****** Please turn over and complete other side ******

Respiratory	Yes	No	?
19. Do you have asthma?			
20. Have you ever had tuberculosis or HIV?			

Gentio-Urinary	Yes	No	?
21. Have you ever had a sexually transmitted infection (syphilis, gonorrhea, etc.)?			

Endocrine System	Yes	No	?
22. Has a physician ever diagnosed you with diabetes?			

Nervous System	Yes	No	?
23. Have you ever had a nervous breakdown?			
24. Has a physician ever told you that you had epilepsy?			
25. Do you consider yourself a nervous person?			

Bone and Joints	Yes	No	?
26. Do you have arthritis or rheumatism?			

Dental	Yes	No	?
27. Have you ever had gum treatments?			
28. Do you think your teeth are moving or drifting?			
29. Do you grind or clench your teeth when you are nervous or sleeping?			
30. Do you smoke?			

Female patients only	Yes	No	?
31. Are you pregnant?			
32. Do you take any medication for Osteoporosis?			

Additional Information or Updates

Emergency Contact and Patient Signature

In case of an emergency, contact: Name _____ Phone _____

Patient/Guardian Signature _____ Date _____