MEDICAL HISTORY: Patient:_____

Primary Care Physician:_____ Phone: _____ Date of last medical exam:_____
Other Physician: _____ Phone: _____ Specialty:_____

How would you describe your present health? (select one) ◯ GOOD ◯ FAIR ◯ POOR

Yes	No	
◯	◯	Has there been any change in your general health in the past year?
◯	◯	Have you had a serious illness, operation, or hospitalization in the past 5 years?
◯	◯	Do you need to restrict your activity or work in any way, due to your current health?
◯	◯	Have you ever had any prolonged or unusual bleeding following a dental procedure?
◯	◯	Have you ever had any complications following dental treatment?
◯	◯	Have you had any injury or trauma to your face or jaw?
◯	◯	Have you ever had an adverse reaction to any dental anesthetics, sedatives, or drugs?
◯	◯	Has your doctor told you to take antibiotics before a dental procedure? Do you need to be premedicated?
◯	◯	Have you taken or do you take Aredia, Zometa, Fosamax or any other Bisphosphonates?
◯	◯	Do you take any medications? Please list ALL medications as well as any OTC medications or supplements:

◯ ◯ Are you allergic to any of the following? If yes, please explain: _____

Aspirin ☐ Codeine ☐ Penicillin ☐ Latex ☐ Metal ☐ Anesthetic ☐ Other ☐

◯ ◯ Do you smoke or use smokeless tobacco now? Have you ever smoked? How many packs per day? _____

◯ ◯ Do you use any kind of alcohol? If so, how much: _____ per _____ (day, week, month)

◯ ◯ Do you have any history of substance abuse or do you currently use recreational drugs?

Do you have, or have you had, any of the following? (please select) ☐ COVID

☐ AIDS/HIV Positive	☐ Chemotherapy/Radiation	☐ Heart Attack	☐ Mental Health Treatment
☐ Alzheimer's Disease	☐ Cold Sores/Fever Blisters	☐ Heart Pacemaker	☐ Mitral Valve Prolapse
☐ Angina/Chest pains	☐ Congenital Heart Disorder	☐ Heart Disease	☐ Neurological Disorders
☐ Arthritis/Gout	☐ Cough frequently	☐ Hemophilia	☐ Organ Transplant
☐ Artificial Heart Valve	☐ Diabetes type? _____	☐ Hepatitis type? _____	☐ Osteoporosis
☐ Artificial Joint	☐ Emphysema	☐ High Blood Pressure	☐ Rheumatic Fever
☐ Asthma	☐ Epilepsy or Seizures	☐ Hives or Skin Rash	☐ Sinus Trouble
☐ Blood Disease	☐ Esophageal Reflux	☐ Kidney Problems	☐ Sleep Apnea
☐ Blood Transfusion	☐ Fainting Spells/Dizziness	☐ Leukemia	☐ Stroke
☐ Bruise Easily	☐ Gastrointestinal Problems	☐ Liver Disease	☐ Thyroid Disease
☐ Cancer type?_____	☐ Glaucoma	☐ Low Blood Pressure	☐ Tuberculosis

Do you have any disease, problem or condition, not listed above? Please explain

WOMEN, check all that are appropriate: ☐ I am pregnant/trying to get pregnant ☐ I am taking birth control pills ☐ I am nursing

To the best of my knowledge, the questions on this form 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 the dental office of any changes in medical status.

_____ _____

Signature of Patient, Parent, or Guardian Date:

perioindy
SARAH HERD, DDS, MSD

REGISTRATION:

Name: _____ Name you prefer: _____ Sex: M / F

Birth Date: ____/____/____ SSN: _____-____-_____ Email: _____

Address: _____ City: _____ State: ____ Zip: _____

Best Phone #: ( ) _____ (OHmOWkOCell) Alternate Phone #: ( ) _____ (OHm OWk OCell)

Preferred Pharmacy and Location: _____Occupation:_____

General Dentist: _____ Referred by: _____

Emergency Contact: _____ Relationship: _____ Phone #: ( ) _____

INSURANCE:

Subscriber's Name: _____ Subscriber's Address: _____ Relationship to Patient: _____

Subscriber's SSN: _____-____-_____ Subscriber's DOB: ____/____/____

Employer: _____ ID #:_____ Group #:_____

Insurance Company: _____ Insurance Company Phone: ( ) _____

Insurance Address: _____ City: _____ State: ____ Zip: _____

Do you have Secondary Insurance? O Yes O No

Insurance eligibility and estimated benefits are based upon information we receive from you and your insurance company. Estimates are not a guarantee of insurance payment and final determination of benefits of is calculated at the time the insurance claim is processed. Regardless of estimated insurance coverage, I understand that any fee incurred will be my responsibility and I will keep my account current. I understand in signing this statement that I am financially responsible to Perio Indy for all fees incurred.

Signature: _____Date: _____

DENTAL HISTORY:

What is your main dental problem: _____

Describe any dental pain you have now: _____Date of last cleaning: _____

Circle any of the following you have now:

- ☐ loose teeth
- ☐ missing teeth
- ☐ jaw clicking
- ☐ clenching/grinding habit
- ☐ pain in jaw joints
- ☐ bleeding gums
- ☐ puffy or sore gums
- ☐ discharge from gums
- ☐ bad odor in mouth
- ☐ bad taste in mouth
- ☐ food packing between teeth
- ☐ sensitive teeth
- ☐ dry mouth
- ☐ burning tongue

Have you had previous periodontal (gum) treatment? _____When: _____By Whom: _____

Have I treated any of your family or friends? _____ Who: _____