Anchor Periodontics

PATIENT INFORMATION...

Date

❑Mr . ❑ Mrs . ❑ Ms . ❑ Dr . First Name M .I . Last Name Nickname

Sex: ❑ Male ❑ Female Birth Date Age Social Security Number

Street Apt . City State Zip Home Tel .( ) Cell .( ) E-mail Did you find our practice online? ❑Yes ❑No Referred By

FIRST NAME LAST NAME

Have you ever been a patient of our practice? ❑Yes ❑No Has a family member ever been a patient of our practice? ❑Yes ❑No Dentist

Medical Doctor

FIRST NAME LAST NAME FIRST NAME LAST NAME

Driver's Lic .# Nearest relative not living with you Tel .( ) Employer Bus . Tel .( ) Personal Payment Type: ❑Cash ❑Check ❑Credit Card In

FIRST NAME LAST NAME

case of emergency, please contact Tel . ( ) Relation

PHARMACY INFORMATION...

Pharmacy Name Address

Tel . ( )

WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT...

❑Self (If self, skip this section) ❑ Spouse ❑ Father ❑ Mother ❑ Other Name

S .S .# Birth Date Street Apt . City Age Tel .( )

FIRST NAME LAST NAME

State Zip

Driver's Lic .# Employer Bus . Tel .( )

SPOUSE OR OTHER GUARANTOR INFORMATION (if different from above)...

Name Relation S .S .# Birth Date

FIRST NAME LAST NAME

Street Apt . City State) Zip

Tel . ( ) Employer Bus . Tel .( )

INSURANCE INFORMATION...

Student: . . . . . ❑ ❑ Part Time ❑ Not . . . . . School Name and Address

SCHOOL NAME ADDRESS

Full Time

Marital Status: . . ❑ ❑Divorced ❑Widow ❑Single ❑Legally Separated

CITY STATE ZIP

Married

Employed: . . . . . ❑Full ❑ Part Time ❑ Retired ❑ Not . . . . . Do you belong to a PPO ❑Yes ❑No

T HMO?

PRIMARY DENTAL INSURANCE CO...

Employer Insurance Company Name I .D . # Address

Tel .( ) Group # Group Name Policy Holder Relation

Birth Date Sex:

ADDRESS CITY

STATE ZIP

FIRST NAME LAST NAME

❑ M ❑ F Soc . Sec . #

SECONDARY DENTAL INSURANCE CO...

Employer Insurance Company Name I .D . # Address

Tel .( ) Group # Group Name Policy Holder Relation

Birth Date Sex:

ADDRESS CITY

STATE ZIP

FIRST NAME LAST NAME

❑ M ❑ F Soc . Sec . #

DENTAL INFORMATION...

Reason for today's visit Are you in pain? ❑ Yes ❑ No, For How Long?

Please indicate any of the following problems by checking off the corresponding box:

- ❑ Discomfort, clicking, or popping in jaw
- ❑ Red, swollen, or bleeding gums
- ❑ A removable dental appliance
- ❑ Blisters / sores in or around the mouth
- ❑ Prolonged bleeding from an injury / extraction
- ❑ Recent infections or sore throat
- ❑ My teeth are sensitive to: ❑ Hot ❑Cold ☐ Sweets ❑ Biting
- ❑ Lost / broken filling(s)
- ❑ Teeth grinding / clenching
- ❑ Ringing in ears
- ❑ Broken / chipped tooth
- ❑ Gum disease
- ❑ Other
- ❑ Stained teeth
- ❑ Locking jaw
- ❑ Bad breath
- ❑ Burning tongue / lips
- ❑ Toothache
- ❑ Difficulty closing jaw
- ❑ Difficulty opening jaw
- ❑ Loose / shifting teeth
- ❑ Food caught between teeth
- ❑ Swelling / lumps in mouth

Last dental exam Last dental x–rays Times a day you brush? Times a week you floss?

How would you rate your smile? (worst) 1 2 3 4 5 6 7 8 9 10 (best) Would you like whiter teeth? ❑ Yes ❑ No

What type of toothbrush bristles do you use? ❑ Soft ❑ Medium ❑ Hard

Patient's Name_____

MEDICAL HISTORY...

Are you in good health? ❑ Yes ❑ No • Height_____ Weight_____ • Are you under the care of a physician? ❑ Yes ❑ No

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ❑ Yes ❑ No

Have you had any illness, operation, or been hospitalized in the past five years? ❑ Yes ❑ No

Have you ever had general anesthesia? ❑ Yes ❑ No • Have you, or a family member, had any unusual or serious reactions to general anesthesia? ❑ Yes ❑ No

Do you have, or have you had, any of the following diseases, medical conditions, or procedures?

YN
- ❑ ❑Rheumatic fever
- ❑ ❑High blood pressure
- ❑ ❑Low blood pressure
- ❑ ❑Mitral valve prolapse
- ❑ ❑Heart murmur
- ❑ ❑Chest pain / Angina
- ❑ ❑Heart attack(s)
- ❑ ❑Irregular heart beat
- ❑ ❑Cardiac pacemaker
- ❑ ❑Heart surgery
- ❑ ❑Damaged heart valves
- ❑ ❑Pneumonia / Bronchitis / Chronic cough
- ❑ ❑Chronic fatigue / Night sweat
- ❑ ❑Trouble climbing 1-2 flights of stairs
- ❑ ❑Anemia
- ❑ ❑Asthma

YN YN
- ❑ ❑Mental health problems
- ❑ ❑Problems with immune system *(possibly from med. / surg.)*
- ❑ ❑Delay in healing
- ❑ ❑Hay fever / Sinus problems
- ❑ ❑Snoring
- ❑ ❑Sleep apnea / CPAP
- ❑ ❑Respiratory problems
- ❑ ❑Tuberculosis
- ❑ ❑Emphysema
- ❑ ❑Do you smoke or vape *If so, how much a day* _____
- ❑ ❑Do you use chewing tobacco
- ❑ ❑A history of marijuana or other drug use
- ❑ ❑A history of alcohol abuse

- ❑ ❑Abnormal bleeding
- ❑ ❑Bleeding tendency
- ❑ ❑Blood transfusion
- ❑ ❑Blood disorder
- ❑ ❑Bruise easily
- ❑ ❑Eye disease / Glaucoma
- ❑ ❑Jaundice / Liver disease
- ❑ ❑Hepatitis
- ❑ ❑Gallbladder trouble
- ❑ ❑Fainting spells
- ❑ ❑Convulsions / Epilepsy
- ❑ ❑Stroke
- ❑ ❑Thyroid trouble
- ❑ ❑Diabetes
- ❑ ❑Low blood sugar
- ❑ ❑Are you on dialysis

YN
- ❑ ❑Kidney trouble
- ❑ ❑Sexually transmitted diseases
- ❑ ❑Contagious diseases
- ❑ ❑Infectious mononucleosis
- ❑ ❑Swollen ankles
- ❑ ❑Arthritis / Joint disease
- ❑ ❑Prosthetic implant
- ❑ ❑Joint replacement
- ❑ ❑Osteoporosis / Osteopenia
- ❑ ❑Osteonecrosis
- ❑ ❑Stomach ulcers / acid reflux
- ❑ ❑GI troubles / IBS / Colitis
- ❑ ❑Tumor or growth
- ❑ ❑Cancer / Radiation / Chemotherapy
- ❑ ❑Are you on a diet
- ❑ ❑Contact lenses

MEDICATION & ALLERGIES...

Are you now taking:

Y N
- ❑ ❑Nerve pills
- ❑ ❑Diet pills

YN
- ☐ ❑Pain killers (including aspirin)
- ❑ ❑Tranquilizers

YN
- ❑ ❑Muscle relaxers
- ❑ ❑Insulin

YN
- ☐ ❑Stimulants
- ☐ ❑Antidepressants
- ☐ ❑Blood thinners (Coumadin, Aspirin, Eliquis, Xarelto)
- ☐ ❑Are you taking, or have you ever taken bone density meds, RANKL inhibitors or bisphosphonates such as Denosumab, Fosamax, Boniva, Actonel, IV-Zometa, Aredia, Reclast, Prolia, Xgeva, or Evista in the past 12 years?

Please list any other medication(s) you are taking (including natural, herbal, or homeopathic products):

MEDICATION	DOSAGE	FREQUENCY	MEDICATION	DOSAGE	FREQUENCY

Are you allergic to, or had a reaction to:

YN
- ❑❑Penicillin
- ❑❑Sodium pentothal / Valium / other tranq.
- ❑❑Sulfa

YN
- ❑❑Sulfa drugs
- ❑❑Aspirin
- ❑❑Eggs / Yolk

YN
- ❑❑Local anesthetic (numbing med)
- ❑❑Codeine or other narcotics
- ❑❑Sulfites

YN
- ❑ ❑Amoxicillin
- ❑ ❑Latex
- ❑❑Do you have any known allergies

Please list any other medication or antibiotic you are allergic to:

MEDICATION / ANTIBIOTIC NAME	MEDICATION / ANTIBIOTIC NAME

Please list any allergies other than drug

1-4 below for women only: *(Women note: antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician / gynecologist for assistance regarding additional methods of birth control.)*

1) Is there a possibility of pregnancy? ❑Yes ☐ N

2) Expected delivery date: _____

3) Are you nursing? ☐ Yes ❑No o

4) Are you taking birth control pills: ❑Yes ❑No