Campus Commons
Periodontics

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CONFIDENTIAL PATIENT MEDICAL HISTORY

Patient Name:_____ Date of Birth: ___/___/___ Age:_____ Sex: ( ) M ( ) F

If a minor, Parent(s) Name:_____ School Attending:_____

Home Address: _____ City: _____ State: _____ Zip: _____

Occupation: _____ Employer: _____ E-mail: _____

Business Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (___)_____Work: (___)_____ Cell: (___)_____ Soc. Sec. # _____

Check One: _____ Single _____ Married_____ Divorced_____ Separated _____ Widowed Driver's Lic. _____

Spouse's Name: _____ Spouse's Employer: _____

Employer's Address: _____City: _____ State: _____ Zip: _____

In case of emergency, who should be notified? _____

Relation to you: _____ Phone: (___)_____

FINANCIALLY RESPONSIBLE PARTY: (For this Account): _____

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

Driver's License # _____ Date of Birth: _____ Soc. Sec. #: _____

Currently Patient At This Office: ( ) Y ( ) N

IF YOU HAVE DENTAL INSURANCE, PLEASE COMPLETE THE FOLLOWING

PRIMARY INSURANCE

Name of insured: _____

Date of Birth: _____/_____/_____ Soc. Sec. # _____

Name of Employer: _____

Name of Dental Insurance: _____

Group #: _____ Phone: (___)_____

Address: _____

City: _____ State: _____ Zip: _____

SECONDARY INSURANCE

Name of insured: _____

Date of Birth: _____/_____/_____ Soc. Sec. # _____

Name of Employer: _____

Name of Dental Insurance: _____

Group #: _____ Phone: (___)_____

Address: _____

City: _____ State: _____ Zip: _____

PLEASE TURN PAGE OVER AND COMPLETE THE OTHER SIDE

MEDICAL HISTORY

What are your present dental concerns?	
Who referred you for therapy?	
Dentist's Name:	Phone: ( )
Physician's Name:	Phone: ( )
Date of last Physical:	Kaiser #:

Have you been hospitalized or had a major operation?	(Y) (N)	NOTES:
Have you ever had a serious head or neck injury?	(Y) (N)	
Do you use controlled substances?	(Y) (N)	
Do you take, or have you taken, Phen-Fen or Redux?	(Y) (N)	
Have you taken IV Bisphosphonates?	(Y) (N)	
Are you on a special diet?	(Y) (N)	
Do you use tobacco?	(Y) (N)	
How much?		

What medications, pills, or drugs are you taking?

What medications are you allergic to?

Do you have, or have you had any of the following?

AIDS/HIV	Y	N	Cortisone Therapy	Y	N	Hemophilia	Y	N	Recent Weight Lost	Y	N
Alzheimers Disease	Y	N	Diabetes	Y	N	Hepatitis A/B	Y	N	Renal Dialysis	Y	N
Anaphylaxis	Y	N	Drug Addiction	Y	N	Hepatitis C	Y	N	Rheumatic Fever	Y	N
Anemia	Y	N	Easily Winded	Y	N	Herpes	Y	N	Latex Allergy	Y	N
Angina	Y	N	Emphysema	Y	N	High Blood Pressure	Y	N	Scarlet Fever	Y	N
Arthritis/Gout	Y	N	Epilepsy or Seizures	Y	N	Hives/Rash	Y	N	Shingles	Y	N
Artificial Heart Valve	Y	N	Excessive Bleeding	Y	N	Hypoglycemia	Y	N	Sickle Cell	Y	N
Artificial Joint	Y	N	Excessive Thirst	Y	N	Irregular Heartbeat	Y	N	Sinus Trouble	Y	N
Asthma	Y	N	Fainting Spells/Dizziness	Y	N	Joint Problems	Y	N	High Cholesterol	Y	N
Blood Disease	Y	N	Frequent Cough	Y	N	Kidney Problems	Y	N	Stomach Disease	Y	N
Blood Transfusion	Y	N	Frequent Diarrhea	Y	N	Leukemia	Y	N	Stroke	Y	N
Breathing Problems	Y	N	Frequent Headaches	Y	N	Liver Disease	Y	N	Swelling of Limbs	Y	N
Bruise Easily	Y	N	Genital Herpes	Y	N	Low Blood Pressure	Y	N	Thyroid Disease	Y	N
Cancer	Y	N	Glaucoma	Y	N	Lung Disease	Y	N	Tonsillitis	Y	N
Chemotherapy	Y	N	Hay Fever	Y	N	Mitral Valve Prolapse	Y	N	Tuberculosis	Y	N
Chest Pain	Y	N	Heart Attack/Failure	Y	N	Pain in Jaw Joints	Y	N	Tumors or Growths	Y	N
Cold Sores	Y	N	Heart Murmur	Y	N	Parathyroid Disease	Y	N	Ulcers	Y	N
Heart Disorder	Y	N	Heart Pace Maker	Y	N	Psychiatric Care	Y	N	Venereal Disease	Y	N
Convulsions	Y	N	Heart Trouble/Disease	Y	N	Radiation Treatment	Y	N	Yellow Jaundice	Y	N

AUTHORIZATION AND CONSENT RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I also give my consent to any advisable and necessary dental procedures, medications, or anesthetics to be administered by the attending dentist or by the supervised staff for diagnostic purposes or dental treatment. I understand that there is a possibility of complications developing during or after any type of dental treatment. I agree that if I fail to co-operate fully with the doctor and staff, my treatment can be discontinued at any time.

Your first visit with the doctor is a consultation appointment ( ). At this time diagnosis and treatment of your specific problem will be discussed. If X-rays are taken there will be an extra charge. Payment or insurance co-payment is due at the time of the visit. Insurance forms will be filled out as service to you. I understand that my dental insurance carrier may pay less than the actual bill for services. Please discuss any financial arrangements with the front desk. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I received a copy and understand the office financial policy regarding missed appointments, cancellations, delinquent accounts, and insurance.

Signature of patient (or parent if minor): _____ Date: _____