AUSTIN IMPLANTS &PERIODONTICS

Answers to the following questions are for our records only and will be kept confidential. Date _____

Patient Information

Your Name _____ Nickname _____ SS# _____ - _____ - _____

Birth Date _____ / _____ / _____ Age _____ Height _____ Weight _____ Sex: ☐M ☐F Driver's License # _____

Address _____ City _____ State _____ ZIP _____

Home Phone ( ) Cell Phone ( ) Email _____@_____

Occupation _____ Employer _____ Work Phone ( )

Spouse's Name _____ Parent/Guardian for Minor Patient _____

Emergency Contact _____ Phone ( ) Relationship _____

Responsible Party (if different from patient)

Name _____ Relationship to Patient: ☐ Spouse ☐ Parent ☐ Guardian

Address _____ City _____ State _____ ZIP _____

Home Phone ( ) Cell Phone ( ) Email _____@_____

Employer _____ Work Phone ( )

Dental Insurance

Policyholder's Name _____ Birth Date _____ / _____ / _____ SS# _____ - _____ - _____

Insurance Company _____ ID# _____ Group No. _____

Health History

For your safety and to assist us in accurately diagnosing and treating you, please carefully review this form completely and fill out areas which pertain to you. **All information is private and confidential.**

Dental History

Who referred you to our office? _____

Your general dentist (if different from referring dentist):

Dr. _____

How long have you been a patient there? _____

When was your last cleaning? _____

How often do you go for cleanings?

☐ 3 months ☐ 6 months ☐ not as often as I should

Have you ever had gum surgery before? ☐ YES ☐ NO

Have you had surgical orthodontics? ☐ YES ☐ NO

Are you dissatisfied with the appearance of your teeth or gums? ☐ YES ☐ NO

If yes, explain: _____

Have you had teeth (other than wisdom teeth) removed? ☐ YES ☐ NO

Have these missing teeth affected your chewing? ☐ YES ☐ NO

Have you ever declined needed dental treatment? If so, for what reason(s)?

☐ Time ☐ Fear ☐ Finances ☐ other: _____

Check any of the following if you have or recently had:

☐ teeth sensitivity to:
- ☐ heat
- ☐ cold
- ☐ sweets
- ☐ biting/chewing

☐ loose/loosening teeth

☐ snoring

☐ diagnosed with sleep apnea

☐ use a sleep appliance such as a CPAP

☐ been told you grind/clench your teeth

☐ are aware that you grind/clench your teeth

☐ wear an occlusal/night guard

☐ been recommended to use an occlusal/night guard

☐ food catching between teeth

☐ gums bleed when brushing/flossing

☐ swollen gums

☐ bad breath or bad taste

☐ jaw pain

☐ unable to open or close jaw

☐ clicking of jaws

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MEDICAL HISTORY

Any health problems or medications that you are taking may have an effect on your oral and periodontal health, so please review this portion carefully and completely fill out which areas that pertain to you. **All information is private and confidential.**

List your current physician(s):

_____ Type _____ Phone ( ) How long? _____

_____ Type _____ Phone ( ) How long? _____

Date of last physical exam including bloodwork _____ Findings _____

Have there been any changes in your general health last year?	☐ YES	☐ NO	If YES, please explain: _____
Are you under a physician's care other than for routine checkups?	☐ YES	☐ NO	If YES, please explain: _____
Have you ever been hospitalized or had a major operation in past 10 years?	☐ YES	☐ NO	If YES, please explain: _____
Have you ever had excessive bleeding that required treatment?	☐ YES	☐ NO	If YES, please explain: _____
Have you had complications from prior sedation/anesthesia?	☐ YES	☐ NO	If YES, please explain: _____
Have you taken cortisone or steroids within the last 6 months?	☐ YES	☐ NO	If YES, please explain: _____
Do you have family members with diabetes?	☐ YES	☐ NO	If YES: ☐ mom's side ☐ dad's side ☐ siblings
Do you currently use tobacco products (smoke, chew, dip)	☐ YES	☐ NO	If YES: How much? _____ How long? _____
Even if not current, have you ever used tobacco in the past?	☐ YES	☐ NO	If YES, when did you quit? ☐ <10 years ☐ > 10 years ago
Do you consume alcohol?	☐ YES	☐ NO	If YES: ☐ occasionally ☐ 4-5 per week ☐ > 5 per week
Have you had a history of alcohol or illicit drug abuse?	☐ YES	☐ NO	If YES, please explain: _____
Have you ever had Botox® or dermal fillers around the mouth/lips?	☐ YES	☐ NO	If YES, how often: _____
Do you or have you ever taken medication for osteoporosis?	☐ YES	☐ NO	If YES, which one? _____ Route: ☐ oral ☐ shot ☐ IV infusion Frequency: ☐ daily ☐ every ___ months

For females: Are you

Pregnant/Trying? ☐ YES ☐ NO Taking oral contraceptives? ☐ YES ☐ NO Nursing? ☐ YES ☐ NO Post-menopause? ☐ YES ☐ NO

For males: Are you

Taking erectile dysfunction meds? ☐ YES ☐ NO Being treated for enlarged prostate? ☐ YES ☐ NO Taking testosterone supplements? ☐ YES ☐ NO

Please list all medications you are taking including over-the-counter drugs, or supplements:

_____

_____

_____

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Tetracycline	☐ Clindamycin	☐ Versed	☐ Tylenol	☐ Codeine	☐ Ibuprofen
☐ Local anesthetics	☐ Amoxicillin	☐ Doxycycline	☐ Sulfa drugs	☐ Valium	☐ Halcion	☐ Norco/Lortab	☐ Latex

☐ Other(s) _____ If yes, what sort of reaction? _____

Do you have, or have had, any of the following? (circle where applicable)

Cardiovascular disease	☐ No ☐ Yes	Artificial joints	☐ No ☐ Yes	Chronic sinus infections	☐ No ☐ Yes
Heart attack	☐ No ☐ Yes	Thyroid disorders	☐ No ☐ Yes	HIV/AIDs	☐ No ☐ Yes
Chest pain	☐ No ☐ Yes	Diabetes: Type I or Type 2	☐ No ☐ Yes	Kidney disease/failure	☐ No ☐ Yes
High blood pressure	☐ No ☐ Yes	Anemia	☐ No ☐ Yes	Dialysis	☐ No ☐ Yes
Heart murmur	☐ No ☐ Yes	Hepatitis A / B / C	☐ No ☐ Yes	Osteoporosis or osteopenia	☐ No ☐ Yes
Congenital heart defect	☐ No ☐ Yes	Liver disease	☐ No ☐ Yes	Osteoarthritis	☐ No ☐ Yes
Artificial heart valve	☐ No ☐ Yes	Jaundice	☐ No ☐ Yes	Rheumatoid arthritis	☐ No ☐ Yes
Rheumatic fever	☐ No ☐ Yes	Tumors or growths	☐ No ☐ Yes	Acid reflux	☐ No ☐ Yes
Pacemaker	☐ No ☐ Yes	Cancer	☐ No ☐ Yes	GI disorders	☐ No ☐ Yes
Heart arrhythmia	☐ No ☐ Yes	Head and neck radiation	☐ No ☐ Yes	Glaucoma	☐ No ☐ Yes
Stroke	☐ No ☐ Yes	Current chemotherapy	☐ No ☐ Yes	Epilepsy/seizures	☐ No ☐ Yes
Shortness of breath	☐ No ☐ Yes	Tuberculosis	☐ No ☐ Yes	Psychiatric disorders	☐ No ☐ Yes
Emphysema/COPD	☐ No ☐ Yes	Sexually transmitted diseases	☐ No ☐ Yes	Anxiety	☐ No ☐ Yes
Asthma	☐ No ☐ Yes	Oral herpes	☐ No ☐ Yes	Depression	☐ No ☐ Yes
Autoimmune disorders	☐ No ☐ Yes	Immunosuppression	☐ No ☐ Yes	Dementia/Alzheimer's	☐ No ☐ Yes

If you need to specify or clarify any of the above conditions: _____

Do you have any medical condition/diseases not listed on above that we should know about? ☐ No ☐ Yes: _____

I attest that to the best of my knowledge, the information provided above is accurate and complete. I understand that providing incorrect or omitting information can be dangerous to my (or the patient's) health. If I ever have any changes in my health or to medications, it is my responsibility to inform the office.

_____ _____

Patient, Parent, or Guardian's Signature Date Doctor's Signature Date