Columbia Periodontal
ASSOCIATES
Periodontal and Implant Dentistry

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PATIENT INFORMATION Today's Date: _____

Patient's Name: _____ Title: _____ Date of Birth: _____

Preferred Name: _____ Email Address: _____

Street Address: _____ City/State/Zip: _____

Home Telephone: _____ Work Telephone: _____ Cell Phone: _____

Patient's Employer: _____ Occupation: _____

Patient's SS #: _____ Spouse/Partner's SS #: _____

Spouse/Partner's Name: _____ Date of Birth: _____

Spouse/Partner's Employer: _____ Occupation: _____

Person Responsible for Account: _____ Relationship to Patient: _____

Dental Insurance: _____ Policy/Subscriber #: _____

Dental Insurance Address: _____ Telephone: _____

PLEASE NOTE: By providing the above contact information, you agree that the information is correct, and you agree for our office to utilize this information to contact you regarding any communication.

Emergency Contact Person: _____ Contact Telephone #: _____

PLEASE NOTE: By listing a contact person above, you agree for our office to disclose any and all pertinent information regarding your care to this person in the event of an emergency.

General Dentist: _____ Date of Last Dental Exam: _____

Medical Physician: _____ Date of Last Medical Exam: _____

Physician's Telephone #: _____

Reason for your visit today: _____

MEDICAL HISTORY

1. Are you under the care of **another physician**? **YES or NO** If Yes, Why? _____

2. Have you been **hospitalized** for any surgical operation or serious illness? **YES or NO** If Yes, When? _____

3. Are you taking any **medications** or **supplements**? **YES OR NO** If Yes, Please list names: _____

   _____

   _____

4. Please circle any of the following medications listed below for **Osteoporosis, Osteopenia, or as Cancer Therapy** that you have taken in the past:

   Fosamax Boniva Actonel Zometa Aredia Bonefos Didronel Other: _____

5. Are you currently taking any **blood thinners** (this includes Aspirin, Plavix, Coumadin)? **YES or NO** If yes, What? _____

6. Have you ever been instructed by a doctor to **PRE-MEDICATE** with antibiotics prior to going to the dentist due to a heart condition or joint replacement? **YES or NO** If Yes, What have you been prescribed? _____

7. Are you currently using tobacco products? **YES or NO** If Yes, What type? _____ How Often? _____

8. Are you **allergic** or have you **reacted adversely** to: (Check, if any)

☐ Local Anesthetics ☐ Penicillin ☐ Sulfa ☐ Codeine ☐ Latex ☐ Demerol ☐ Aspirin ☐ Other Antibiotics

Please list any other drug _____

9. Do you drink **alcoho**l in excess or have you ever been **treated for alcohol abuse**? YES or NO If Yes, please explain:_____

_____

10. Do you use **recreational drugs** or **medications not prescribed** by your physician? **YES or NO** If Yes, please explain:_____

_____

11. **WOMEN ONLY**: Are you pregnant? **YES or NO** Are you nursing? **YES or NO** Do you take birth control pills or hormone pills? **YES or NO**

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

Heart Disease/Heart Attack	YES or NO	High Blood Pressure	YES or NO
Angina/Chest Pains	YES or NO	Heart Infection/Endocarditis	YES or NO
Heart Surgery/Stents	YES or NO	Peripheral Vascular Neuropathy	YES or NO
Cardiac Pacemaker	YES or NO	Rheumatic Fever/Mitral Valve Prolapse/Murmur	YES or NO
Asthma/Shortness of Breath	YES or NO	Emphysema	YES or NO
Tuberculosis	YES or NO	Chronic Obstructive Pulmonary Disease	YES or NO
Fainting Spells/Seizures	YES or NO	Epilepsy/Convulsions	YES or NO
Stroke/Transient Ischemic Attacks (TIAs)	YES or NO	Fibromyalgia	YES or NO
Organ Transplant	YES or NO	AIDS/HIV Positive	YES or NO
Diabetes	YES or NO	MRSA/VRSA	YES or NO
Hepatitis: Circle Type A B C	YES or NO	Thyroid/Parathyroid Problems	YES or NO
Liver Disease/Jaundice	YES or NO	Anxiety	YES or NO
Radiation Therapy/Chemotherapy	YES or NO	Anemia	YES or NO
Irritable Bowel Syndrome/Colitis/Diverticulitis	YES or NO	Crohn's Disease	YES or NO
Acid Reflux/Peptic Ulcer Disease	YES or NO	Swollen Ankles	YES or NO
Kidney Disorders/Stones	YES or NO	Arthritis	YES or NO
Joint Replacement/Joint Implants	YES or NO	Narrow Angle Glaucoma	YES or NO
Sleep Apnea	YES or NO	Other Condition(s) not listed _____	YES or NO
Cancer: List Type _____	YES or NO	_____	

FOR DOCTOR'S USE ONLY

_____

_____

_____

AUTHORIZATION and RELEASE

I certify that I have read and understand the above information and to the best of my knowledge, all questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the doctor/doctors in this practice to release any information including the diagnosis and the records of any treatment or examination rendered to me or my dependent during the period of such dental care to third party payers and/or health practitioners.

Signature of Patient (or parent if patient is a minor): _____

Medical History Reviewed By: _____ Date: _____