PIKES PEAK
PERIODONTICS

Patient Information

Patient Name:_____ DOB:_____/_____/_____

If minor Parent/Guardian Name:_____ Relationship:_____

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

Cell Phone:_____ Home Phone:_____ Email:_____

Emergency Contact Name:_____ Phone #:_____

Pharmacy you prefer:_____ Location:_____

Referring Dentist:_____ Office:_____

Patient Dental History

General Dentist (If same as referring dentist you can leave blank):_____

Date of last cleaning:_____ How often do you brush:_____

*****The following questions must be circled individually. Please circle one*****

-Do your jaw joints click or pop? YES or NO
-Do you grind your teeth? YES or NO
-Do you have any loose teeth? YES or NO
-Do you clench during the day? YES or NO
-Do your gums bleed when you floss or brush? YES or NO
-Do you often have fever blisters? YES or NO
-Has anyone in your family lost all their teeth? YES or NO
-Any tobacco use currently or in the past? How much?_____ YES or NO
-Do you have pain in your jaw? YES or NO
-Do you have headaches regularly? YES or NO
-Have you had Orthodontic Treatment? YES or NO
-Do you have bad breath or a bad taste? YES or NO
-Have you had Periodontal Treatment? YES or NO
-Alcohol use? How much? _____ YES or NO

Medical History

Medical Doctors Name:_____ Phone:_____
Date of last visit:_____ Reason:_____
Are you currently receiving any medical treatment? YES or NO
Reason:_____
Are you taking any medications regularly? YES or NO
Which ones:_____
Do you require premedication (antibiotics) for any reason? YES or NO
Reason:_____

******Do you now, or in the past, had any of the following:

-Anemia	YES or NO	-Arthritis	YES or NO
-Bladder Problems	YES or NO	-Kidney Problems	YES or NO
-Bleeding	YES or NO	-Clotting Problems	YES or NO
-Liver Problems	YES or NO	-Low Blood Pressure	YES or NO
-Diabetes	YES or NO	-Recent Surgery	YES or NO
-Osteoporosis	YES or NO	-Gastric Ulcer	YES or NO
-Excessive Thirst	YES or NO	-Thyroid Problems	YES or NO
-Veneral Disease	YES or NO	-Hepatitis	YES or NO
-High Blood Pressure	YES or NO	-Family Diabetes	YES or NO
-Lung Problems	YES or NO	-Rheumatic Fever	YES or NO
-Heart Conditions	YES or NO	-Glandular Problems	YES or NO
-Psychiatric Problems	YES or NO	-Substance Abuse	YES or NO
-Aids	YES or NO	-Artificial Joints	YES or NO
-Pacemaker/Stent	YES or NO		

IF YES TO ANY, REASON:_____

Have you ever taken Cortisone?	YES or NO	When and how long?	_____
Have you ever taken Anticoagulants?	YES or NO	When and how long?	_____
Do you take Aspirin daily?	YES or NO	Dosage?	_____
Do you take a Bisphosphanate drug?	YES or NO	How long?	_____
Do you tire easily?	YES or NO	When?	_____
Do you bruise easily?	YES or NO	Does it linger?	_____
Do you consider your health good?	YES or NO	I no, explain:	_____
Do you take daily vitamins?	YES or NO	Females-Menopause?	YES or NO

******Are you now or have you ever been ALLERGIC to any of the following medications?

-Aspirin	YES or NO	-Antihistamines	YES or NO
-Barbiturates	YES or NO	-Codeine	YES or NO
-Demerol	YES or NO	-Novocaine	YES or NO
-Penicillin	YES or NO	-Latex	YES or NO

-Antibiotics YES or NO If yes, which Antibiotics?_____

Patient Signature: _____ Date: _____
Doctor Signature: _____ Date: _____