PERIO SPECIALIST®
*oral care beyond teeth*

# New Patient Registration Form

First Name

Last Name

Birthdate

Mobile Phone #

Email

Preferred Pharmacy

Preferred Pharmacy Phone #

Emergency Contact Name

Emergency Contact Phone #

## DENTAL HISTORY

How fearful are you of dental treatment (10 being the most)?.....

Have you ever had braces, orthodontic treatment, or had your bite adjusted?..... ☐ Yes ☐ No

Have you ever had gum surgery?..... ☐ Yes ☐ No

Have you ever had deep cleaning of your teeth (scaling and root planning) for gum pockets?..... ☐ Yes ☐ No

If so, when was the last time.....

Have you ever had a dental implant?..... ☐ Yes ☐ No

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**I certify** I have read and I understand the questions. I acknowledge my questions have been answered to my satisfaction. I will not hold my doctor, or any other member of his/her team, responsible for any errors or omissions that I have made in the completion of this form.

I permit the office to communicate with me via text message.

If I have dental insurance, my signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

I hereby acknowledge a copy of the Notice of Privacy Practices has been made available to me (see form on website). I have been given the opportunity to ask any questions I may have regarding this Notice.

X _____ X _____

Signature of patient (Parent or Guardian if Minor) Date

## MEDICAL HISTORY...

**Patient Name** _____ **Birth Date** _____

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

Have you had the COVID vaccination? ❑ Yes ❑ No

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? ❑ Yes ❑ No

## WOMEN ONLY...

**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 ❑ No
**2)** Expected delivery date:
**3)** Are you nursing? ❑ Yes ❑ No
**4)** Are you taking birth control pills: ❑ Yes ❑ No

## ALLERGIES...

**Are you allergic to, or had a reaction to:**

| Y | N | | Y | N | | Y | N | | Y | N | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| ❑ | ❑ | Penicillin | ❑ | ❑ | Sulfa drugs | ❑ | ❑ | Local anesthetic (numbing med) | ❑ | ❑ | Amoxicillin |
| ❑ | ❑ | Aspirin | ❑ | ❑ | Codeine or other narcotics | ❑ | ❑ | Latex | ❑ | ❑ | Do you have any known allergies |

*Please list any allergies not listed above* _____

## MEDICAL CONDITIONS...

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

| Y | N | | Y | N | | Y | N | | Y | N | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| ❑ | ❑ | AIDS / HIV | ❑ | ❑ | Dementia | ❑ | ❑ | High blood pressure (possibly from med. / surg.) | ❑ | ❑ | Prosthetic implant |
| ❑ | ❑ | Alzheimer's | ❑ | ❑ | Diabetes | ❑ | ❑ | High cholesterol | ❑ | ❑ | Radiation |
| ❑ | ❑ | Anemia | ❑ | ❑ | Do you smoke or vape | ❑ | ❑ | History of alcohol / drug abuse | ❑ | ❑ | Respiratory problems |
| ❑ | ❑ | Arthritis / Joint disease | | | If so, how much a day_____ | ❑ | ❑ | History of marijuana / drug use | ❑ | ❑ | Rheumatic fever |
| ❑ | ❑ | Asthma | ❑ | ❑ | Do you use chewing tobacco | ❑ | ❑ | Infectious mononucleosis | ❑ | ❑ | Sexually transmitted diseases |
| ❑ | ❑ | Bleeding tendency | ❑ | ❑ | Emphysema | ❑ | ❑ | Irregular heart beat | ❑ | ❑ | Sleep apnea / CPAP |
| ❑ | ❑ | Blood transfusion | ❑ | ❑ | Eye disease / Glaucoma | ❑ | ❑ | Joint replacement | ❑ | ❑ | Special diet |
| ❑ | ❑ | Bronchitis | ❑ | ❑ | Fainting spells | ❑ | ❑ | Kidney trouble | ❑ | ❑ | Stomach ulcers / acid reflux |
| ❑ | ❑ | Bruise easily | ❑ | ❑ | Hay fever / Sinus problems | ❑ | ❑ | Liver disease | ❑ | ❑ | Stroke |
| ❑ | ❑ | Cancer | ❑ | ❑ | Heart attack(s) | ❑ | ❑ | Low blood pressure | ❑ | ❑ | Thyroid trouble |
| ❑ | ❑ | Chest pain / Angina | ❑ | ❑ | Heart murmur | ❑ | ❑ | Low blood sugar | ❑ | ❑ | Trouble climbing 1-2 flights of stairs |
| ❑ | ❑ | Chronic cough | ❑ | ❑ | Heart pacemaker | ❑ | ❑ | Mental health problems | ❑ | ❑ | Tumor or growth |
| ❑ | ❑ | Chronic fatigue / Night sweat | ❑ | ❑ | Heart surgery | ❑ | ❑ | Osteopenia | | | |
| ❑ | ❑ | Convulsions / Epilepsy | ❑ | ❑ | Heart trouble | ❑ | ❑ | Osteoporosis | | | |
| ❑ | ❑ | COVID–19 | ❑ | ❑ | Heart valve issues | ❑ | ❑ | Pneumonia | | | |
| ❑ | ❑ | Delay in healing | ❑ | ❑ | Hepatitis | ❑ | ❑ | Problems with immune system | | | |

*Do you have any medical conditions not listed above* _____

## MEDICATIONS...

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

| MEDICATION | DOSAGE | FREQUENCY | MEDICATION | DOSAGE | FREQUENCY |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

## SIGNATURE...

**X** _____ **X** _____

**Signature of patient** *(Parent or Guardian if Minor)* **Date**

## DOCTOR'S NOTES...

**X** _____ **X** _____

**Signature of dentist** **Date**