Dental Implants & Periodontal Care, P.C.
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706-278-5344

Welcome to our office. We will do our best to make your appointments as convenient as possible. If at any time you have any questions regarding your treatment, your appointments or fees, please feel free to ask. Your kindness in furnishing the following information will be appreciated and will be used in strict confidence to prepare your clinical chart.

Date: _____

Please Circle: Dr. Mr. Mrs. Miss

Patient Name: _____

HEALTH HISTORY INFORMATION

DIRECTIONS:
Answer all questions by circling either YES or NO, and fill in the blank spaces to the best of your ability. If you don't understand a question, consult your dentist. All information will be considered confidential.

1. Date of your last physical examination:_____
2. Have you been hospitalized or had a serious illness within the last 3 years…… Yes No
   If so, what was the problem? _____
3. Are you under the care of a physician? ..... Yes No
   If so, for what condition? _____
4. **Have you been instructed by your medical doctor to take Premedication prior to dental visits? Yes No**
   Type: _____ Amount: _____
5. **Have you had any type of joint (hip/knee) replacement? ..... Yes No**
   Type: _____ Date: _____
6. **Do you have sleep apnea? ……..... Yes No**
7. **Do you use a CPAP machine? ……. Yes No**

8. Do you have or have you had, any of the following diseases or problems?

a. CARDIOVASCULAR

1) Rheumatic Fever …… Yes No
2) Congenital Heart Defect -- Type: _____ Surgery Date: _____ … Yes No
3) Angina Pectoris -- Frequency:_____..... Yes No
4) Myocardial Infarction (Heart Attack) – Date:_____..... Yes No
5) Arrhythmias (Irregular Beat) – Type:_____..... Yes No
6) Cardiac Murmur – Etiology (cause):_____..... Yes No
7) Congestive Heart Failure – Date:_____..... Yes No
8) Heart Surgery – Type: _____ Date: _____..... Yes No
9) Pacemaker implanted – Type: _____ Date: _____.. Yes No
10) Hypertension (High Blood Pressure) – BP: _____/_____..... Yes No
11) Hypotension (Low Blood Pressure) – BP:_____/_____..... Yes No
12) Stroke (CVA) – Date: _____..... Yes No

b. RESPIRATORY DISEASES:

1) Asthma – Severity: _____..... Yes No
2) Emphysema – Severity:_____..... Yes No
3) Bronchitis – Severity: _____..... Yes No
4) Hay Fever or Sinusitis…… Yes No

c. ENDOCRINE DISORDERS:

1) Diabetes – Type Control: _____..... Yes No
2) Hyperthyroidism (High Thyroid) – Treatment: _____..... Yes No
3) Hypothyroidism (Low Thyroid) – Treatment:_____..... Yes No

d. HEMATOLOGIC (BLOOD) DISORDERS:

1) Anemia – Type: _____..... Yes No
2) Bleeding Tendency – Do you bruise easily or bleed excessively when cut? ..... Yes No
Explain: _____

e. PSYCHIATRIC PROBLEMS:

1) Are you presently seeing or have you seen a psychiatrist in the last 3 years? ..... Yes No
Name: _____Phone No: _____

f. INFECTIOUS DISEASES:

1) Hepatitis – Type: _____ Date: _____..... Yes No
2) Venereal Disease – Type: _____ Date: _____..... Yes No
3) Tuberculosis – Date: _____..... Yes No
4) Acquired Immune Deficiency Syndrome (AIDS) / HIV …… Yes No

g. RENAL (KIDNEY) DISEASE:

1) Have you had any kidney infections within the last 3 years? ..... Yes No
Type: _____ Date: _____
2) Have you had any kidney surgery? Type: _____ Date: _____ Yes No
3) Do you take dialysis? …… Yes No

h. MISCELLANEOUS DISEASES OR DISORDERS:

1) Alzheimer _____..... Yes No
2) Parkinson's _____..... Yes No
2) Syncope (Fainting) – Frequency: _____..... Yes No
3) Liver Disease – Type: _____..... Yes No
4) Arthritis – Type: _____..... Yes No
5) Ulcers – Type: _____..... Yes No
6) Glaucoma: _____..... Yes No
7) Radiation Therapy – Type: _____ Date: _____..... Yes No
8) Epilepsy – Treatment: _____..... Yes No
9) Have you had Cancer? – Type: _____ Date: _____ Yes No
10) Do you use Tobacco? – Type: _____..... Yes No
11) Do you use Alcohol? – Socially _____ Daily_____..... Yes No

9. Do you take any of the following medications?

A. Antibiotics (etc.) – Type: _____ Amount: _____..... Yes No
B. Anticoagulants (blood thinners)…….. Yes No
C. Steroids (Cortisone) – Type: _____ Amount: _____ Yes No
D. High Blood Pressure Medicine – Type: _____ Amount: _____ Yes No
E. Tranquilizers – Type: _____ Amount: _____..... Yes No
F. Aspirin – How often: _____..... Yes No

Others:	**Drug**	**Amount**	**How Often**
G.	_____	_____	_____
H.	_____	_____	_____

10. Do you have any allergy or reaction to:

A. Local Anesthetics – Type: _____ Reaction: _____..... Yes No
B. Penicillin or Antibiotics – Type: _____ Reaction: _____..... Yes No
C. Sulfa Drugs – Reaction: _____..... Yes No
D. Aspirin – Reaction: _____..... Yes No
E. Barbiturates or Other Sedatives – Type: _____ Reaction: _____

Others:	**Drug**	**Amount**	**How Often**
F.	_____	_____	_____

11. Have you had difficulty with any dental treatment including extractions? ..... Yes No
If so, explain: _____

12. Do you have any problem or condition not listed above? ..... Yes No
If so, explain: _____

13. Have you had any type of facial implants? ..... Yes No
Type: _____ Date: _____

14. Are you or have you taken any of the following Bisphosphonate drugs? …….. **YES NO**

If **yes**, circle all that apply:

Generic Name	**Brand Name**	**Generic Name**	**Brand Name**
Alendronate	Fosamax	Pamidrenic Acid	Aredia
Clodronic Acid	Bonefos	Risedronate	Actonel or Atelvia
Denosumab	Prolia or Xgeva	Tiludonic Acid	Skelid
Etidronic Acid	Dironel	Zoledronic Acid	Reciast or Zometa
Ibandronate	Boniva		

Bisphosphonates are antiresorptive medicines, which mean they slow or stop the natural process that dissolves bone tissue, resulting in maintained or increased bone density, and strength. Serious problems with bone healing, particularly after dental surgery, have been found in some people taking bisphosphonates. If you are taking bisphosphonates and need dental surgery, talk with your doctor.

Bisphosphates, when administered intravenously for the treatment of cancer, have been associated with osteonecrosis of the jaw (ONJ), with the mandible twice as frequently affected as the maxilla and most cases occurring following high-dose intravenous administration used for some cancer patients. Some 60% of cases are preceded by a dental surgical procedure that involve the bone, and it has been suggested that bisphosphonate treatment should be postponed until after any dental work to eliminate potential sites of infection (the use of antibiotics may otherwise be indicated prior to any surgery).

16. Women only:

1) Are you pregnant? -- Due date: _____..... Yes No

POLICY OF PAYMENT

The policy of payment for dental services in this office will be **cash, check, credit card or CareCredit** at the conclusion of each visit, unless arrangements have been made previously. We do accept payment of co-insurance from a **primary** insurance coverage, but the ultimate responsibility for payment of the account remains that of the patient. We will be happy to assist our patients with completion of insurance forms, including forms for any secondary coverage carried; however, only **primary** coverage will be accepted by this office.

_____ _____

Signature of Patient Date Signature of Dentist Date

_____ _____

Provider Signature Date Provider Signature Date

_____ _____

Provider Signature Date Provider Signature Date