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Diplomat- American Board of Periodontology PRACTICE LIMITED TO PERIODONTICS
University Periodontal Associates, Inc. (713) 523-9040

NAME: _____ HOME PHONE: _____

STREET ADDRESS: _____ CELL PHONE: _____

CITY, STATE: _____ ZIP: _____ E-MAIL: _____

DATE OF BIRTH: _____ SEX: _____ SSN#: _____

EMPLOYER: _____ WORK PHONE: _____

ADDRESS: _____ STE: _____ CITY, STATE, ZIP: _____

PERSON TO CONTACT IN CASE OF EMERGENCY: _____ PHONE: _____

NAME OF INSURANCE CO.: _____ NAME OF INSURED: _____

INSURED D.O.B: _____ INSURED MEMBER ID#: _____

POLICY HOLDER'S EMPLOYER _____ REFERRED BY: _____

_____ FAMILY DENTIST: _____ PHYSICIAN: _____

LAST SEEN/REASON: _____

WHAT IS YOUR BIGGEST CONCERN ABOUT YOUR GUM, MOUTH OR TEETH?

WHEN WAS YOUR LAST VISIT TO YOUR FAMILY DENTIST, AND WHAT WAS THE NATURE OF YOUR VISIT?

HAVE YOU HAD PERIODONTAL TREATMENT BEFORE? (If so, when and where?)

HOW OFTEN DO YOU HAVE YOUR TEETH CLEANED, AND WHEN WERE THEY LAST CLEANED?

PLEASE CHECK ANY OF THE FOLLOWING IF YOU FEEL THEY APPLY TO YOU

<input type="checkbox"/> Swollen or bleeding gums	<input type="checkbox"/> Bad breath or mouth odors	<input type="checkbox"/> Bad tastes
<input type="checkbox"/> Painful gums or teeth	<input type="checkbox"/> Sensitivity to hot or cold	<input type="checkbox"/> Clenching of teeth
<input type="checkbox"/> Loose teeth	<input type="checkbox"/> Increasing spaces between your teeth	<input type="checkbox"/> Other

HOW WOULD YOU FEEL IF YOU HAD TO LOSE YOUR TEETH?

ARE YOU ALLERGIC TO MINOCYCLINE OR IODINE? _____

OTHER ALLERGIES? _____

HEPATITIS/LIVER DISEASE

[] []

ARE YOU CURRENTLY:
PREGNANT

[] []

BREAST FEEDING

[] []

DO YOU HAVE ANY MEDICAL CONDITIONS NOT LISTED ABOVE THAT WE SHOULD KNOW ABOUT?

WHAT IS YOUR HEIGHT? _____ WHAT IS YOUR WEIGHT? _____

HAVE YOU BEEN TREATED FOR ANY TYPE OF CHEMICAL DEPENDENCY? _____

PLEASE LIST ANY MEDICATIONS YOU ARE TAKING: PLEASE INCLUDE **ASPIRIN, VITAMINS, BIRTH CONTROL PILLS, AND ANY OTHER OVER THE COUNTER MEDICATIONS.**

DRUG

DOSAGE

HOW LONG?

NAME OF PHARMACY: _____ PHONE #: _____

LOCATION: _____

CAN YOU TAKE IBUPROFEN? (ADVIL, NUPRIN) _____

ARE YOU TAKING OR HAVE YOU RECENTLY TAKEN DIET CONTROL MEDICATION? YES NO

PATIENT'S SIGNATURE _____ DATE _____

DOCTOR'S SIGNATURE _____ DATE _____