The Perio Pocket

SD Implants and Aesthetics

Patient Information

Name: _____

Date: _____

Date of Birth:_____ Gender: _____

Phone: _____

Address: _____

_____

Insurance + Beneficiary (if not you): _____

* Bring your insurance card with you to your appointment for copies, or send photo of card (both front and back) , we will collect your social security information in office or over the phone

Occupation+ Employer: _____

Preferred email: _____

Health History

1. History of Heart Disease? (__) Y (__) N

**If yes please choose from the list below and state the date of last incident*

    1. Stroke
    2. Heart Attack
    3. Murmur
    4. Hypertension (high blood pressure)
    5. Other _____
    6. Do you wear a pacemaker ? (__) Y (__) N
2. Lung Disease? (__) Y (__) N
    1. Asthma
    2. Emphysema
    3. Smoking? (__) Y (__) N
        1. If yes how often *(include past or current smoking)*_____
3. Diabetes ? (__) Y (__) N *(if yes, circle below)*
    1. Type I
    2. Type II
        1. Most Recent HbA1C_____%
        2. Most Recent Blood Glucose_____
4. Autoimmune Disease ? (__) Y (__) N
    1. If yes specify what type _____
5. Allergies (__) Y (__) N
    1. Hay/Seasonal
    2. Food/medicine _____

6. Bone Disease? (__) Y (__) N
    1. Osteoporosis
    2. Osteopenia
    3. Other _____
    4. Have you ever taken or are currently taking bisphosphonates? (__) Y (__) N
7. Epilepsy or Seizures ? (__) Y (__) N
8. Do you SNORE ? (__) Y (__) N
    1. Do you wear a CPAP ? (__) Y (__) N *(if yes, circle below)*
        1. Nose
        2. Mouth
9. Brain injury ? (__) Y (__) N
10. AIDS or HIV ? (__) Y (__) N
11. Immunodeficiency ? (__) Y (__) N
    1. Diagnosis/Type_____
12. Cancer ? (__) Y (__) N
    1. Radiation (__) Y (__) N
    2. Chemotherapy (__) Y (__) N
    3. Diagnosis/Type_____
12. Past history or current substance abuse? (__) Y (__) N
13. Pregnant or Nursing? __) Y (__) N_____

1. OTHER_____

Date of last complete blood panel: _____

Vitamin D levels checked? (__) Y (__) N

Results_____

Primary Care Physician: _____

Phone:_____

Other Physicians / Specialists: _____

Medications AND Vitamins (please include dose)

_____

_____

_____

_____

_____

Emergency contact NAME and NUMBER : _____

DENTAL HISTORY

1. When was your last cleaning? _____.
2. How often do you receive cleanings? *(Circle One)*

   3-4 months 6 months 1 a year sporadic

3. Do you Clench/Grind your teeth? (__) Y (__) N
   1. Do you wear a night guard? (__) Y (__) N
   2. Do you receive BOTOX for Bruxism? (__) Y (__) N
4. Immediate family History of Gum disease or tooth loss? (__) Y (__) N
5. Feelings on Dentures ?_____

_____

Patient Signature

_____

Doctor Signature

Date HH and DH Updated_____

SCANNED STAMP: