Periodontal Associates, LLC

Periodontics, Dental Implants, TMJ & Facial Pain

33-A Gamecock Ave.
Charleston, SC 29407
(843) 571-0853
(800) 752-6751
FAX (843) 769-7342

info@charlestonperio.com • www.charlestonperio.com

PATIENT REGISTRATION INFORMATION:

Correct answers to the following questions will allow us to treat you on a more individual basis, providing the care appropriate for your particular needs. Check yes or no, whichever applies, in response to the following questions. Your answers are for our records only and will be considered confidential.

Date: _____

A. Mr. / Mrs. / Ms. _____ / _____ / _____ / _____
Last First Initial Name Preferred

B. E-mail Address _____

C. Home Phone _____ Work Phone _____ Cell Phone _____

D. Street Address _____

E. City _____ State _____ Zip _____

F. Soc. Sec. No _____ Birth Date _____ Marital Status _____ Sex ____

G. Employer Name _____ Occupation _____

Name and Address of Dentist _____ For how long? _____

Who may we thank for referring you? _____

Name of any relative or friends treated by Periodontal Associates _____

DENTAL INSURANCE INFORMATION:

Primary Carrier: _____
Name & Address of Dental Insurance Carrier

Subscriber Name: _____ Date of Birth: _____

Group #: _____ ID #: _____ Employer: _____

Secondary Carrier: _____
Name & Address of Dental Insurance Carrier

Subscriber Name: _____ Date of Birth: _____

Group #: _____ ID #: _____ Employer: _____

EMERGENCY INFORMATION:

In case of emergency contact:

Name _____ Relationship _____

Address _____

City _____ State _____ Zip _____ Phone _____

Medical History Update

Name: _____

Preferred Pharmacy _____

Name Tel. Number

1. Do you have or have you had any of the following diseases or problems:

	Yes	No		Yes	No
• Rheumatic fever or rheumatic heart disease	☐	☐	• Fainting spells or seizures	☐	☐
• Chest pain, Angina	☐	☐	• Diabetes	☐	☐
• Heart attack	☐	☐	• Hepatitis, jaundice or liver disease	☐	☐
• Heart murmur, Mitral Valve Prolapse	☐	☐	• Arthritis or inflammatory rheumatism	☐	☐
• H/L blood pressure, arteriosclerosis, stroke	☐	☐	• Digestive system-ulcers or Colitis	☐	☐
• Artificial or replacement valves	☐	☐	• Kidney trouble	☐	☐
• Artificial joint replacement	☐	☐	• Tuberculosis	☐	☐
• Pacemaker	☐	☐	• Immune system disorders	☐	☐
• Sinus trouble	☐	☐	• Anemia	☐	☐
• Asthma	☐	☐	• HIV +	☐	☐

2. Do you require a prophylactic antibiotic before dental appointments ☐ ☐

3. Have you had abnormal bleeding associated with previous extractions, surgery, or trauma? ☐ ☐

4. Do you have sleep apnea or use a C-PAP machine? ☐ ☐

5. Are you taking any of the following: **(IF "YES" STATE DRUG NAME, DOSAGE)**

- Antibiotics ☐ ☐
- Anticoagulants (blood thinners) ☐ ☐
- Medicine for high blood pressure ☐ ☐
- Cortisone (steroids) ☐ ☐
- Tranquilizers ☐ ☐
- Antihistamines ☐ ☐
- Aspirin ☐ ☐
- Insulin ☐ ☐
- Heart medications ☐ ☐
- Other medications (vitamins, etc.) ☐ ☐
- Bisphosphonates **(medication for osteoporosis, ie: Fosamax, Prolia)** ☐ ☐

6. Are you allergic or have you reacted adversely to:

- Local anesthetics ☐ ☐
- Penicillin or other antibiotics ☐ ☐
- Barbiturates, sedatives, or sleeping pills ☐ ☐
- Aspirin ☐ ☐
- Iodine ☐ ☐
- Codeine, Demerol or other narcotics ☐ ☐
- Latex or rubber products ☐ ☐
- Other ☐ ☐

7. Do you use any tobacco products? ☐ ☐

8. **Is there anything of importance in your medical history that has not been asked?** ☐ ☐

WOMEN

9. Are you pregnant? ☐ ☐

10. Are you taking birth control or hormone therapy? ☐ ☐

Patient Signature _____ Date _____

Dentist Signature _____ Date _____

DENTAL HISTORY:

	Yes	No
1. Are you having any discomfort at this time?	❑	❑
If so, where? _____		
2. Have you been pleased with your previous dental treatment?	❑	❑

3. Does dental treatment make you nervous? ❑ No ❑ Slightly ❑ Moderately ❑ Extremely

4. Date of last dental visit _____

	Yes	No
5. Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)?	❑	❑
If so, when _____		

6. Do you have or have you ever had any of the following?

MOUTH	Yes	No	TEETH	Yes	No
Bleeding, sore gums	❑	❑	Loose teeth	❑	❑
Unpleasant taste/bad breath	❑	❑	Sensitive to hot	❑	❑
Burning tongue/lips	❑	❑	Sensitive to cold	❑	❑
Frequent blisters, lips/mouth	❑	❑	Sensitive to sweets	❑	❑
Swelling/lumps in mouth	❑	❑	Sensitive to biting	❑	❑
Ortho treatments (braces)	❑	❑	Food impaction	❑	❑
Clicking/popping jaw	❑	❑	Clenching/grinding	❑	❑
Difficulty opening or closing jaw	❑	❑	If so, when _____		

7. Are you satisfied with the color of your teeth?	❑	❑
Are you satisfied with the position of you teeth?	❑	❑
Is there anything about your upper or lower gums you do not like?	❑	❑
Are you satisfied with your ability to chew?	❑	❑

8. If by magic you could change anything about your teeth, what would it be:

_____

9. Describe the condition or problem for which you are seeking treatment:

_____

_____

DOCTOR'S NOTES:

_____

_____

_____

_____

_____

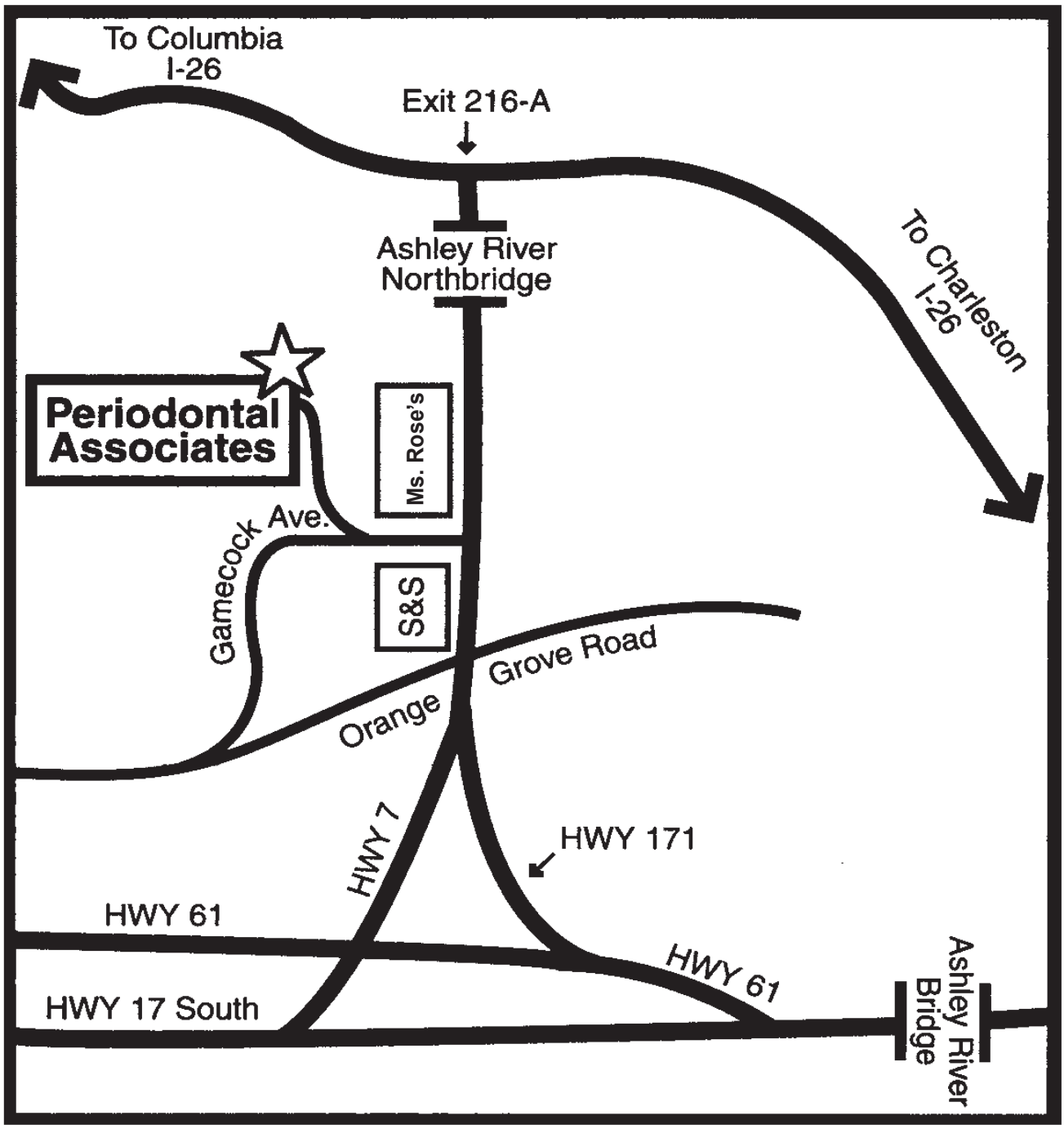
_____

_____

To the best of my knowledge, all of the preceding answers are true and correct. If there is any change in your health history or change in your medication, please inform our office at your next appointment.

Signature of Patient _____ Date _____

Signature of Dentist _____ Date _____


To Columbia
I-26
Exit 216-A
Ashley River
Northbridge
To Charleston
I-26
Periodontal
Associates
Ms. Rose's
Gamecock Ave.
S&S
Grove Road
Orange
HWY 7
HWY 171
HWY 61
HWY 61
HWY 17 South
Ashley River
Bridge