

Lakeland Periodontics, Inc.

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Practice Limited to Periodontics and Surgical Implant Dentistry

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Please answer the following completely. Your answers are for our records and are considered confidential. Your cooperation is appreciated. **PLEASE PRINT.**

Mr. ___ Mrs. ___ Miss ___ Ms. ___ Dr. ___ Child ___ email: _____

Patient's Name: _____ Spouses Name: _____

Mailing Address: Street _____ City _____ St _____ zip _____

Home # () _____ Work() _____ Cell() _____ Emergency contact #() _____

Occupation: _____ Employer _____

Social Security Number _____ - _____ - _____ Sex _____ Age _____ Birthdate ____/____/____

Medical information: Are you now, or have you been under the care of a physician in the past 5 years? ___yes___no

Medical Dr _____ Reason _____ Last physical exam was on _____

Have you had any previous surgeries Y N Have you ever had complications with anesthesia? Y N

Yes No
 Do you need antibiotic Coverage for MVP, joint replacement, Heart valve replacement, heart valve defect, etc, before your dental appointments?

Are you currently taking/or have taken medications for osteoporosis, multiple myeloma, breast or prostate cancer/ Including, but not limited to: Fosamax, Aredia, Actonel, Zometa, Boniva, Denosumab

Do you have/or have you had?

Yes No
 Aids/HIV
 ANEMIA
 ARTHRITIS/RHEUMATISM
 ASTHMA/HAY FEVER
 BLEEDING PROBLEMS
 BLOOD DISEASE (ANEMIA)
 CANCER/TUMOR
 CHEMOTHERAPY
 CHEST PAINS (ANGINA)
 CORTISONE /STEROIDS
 DIABETES (BLOOD SUGAR)
 DRUG/ ALCOHOL ADDICTION
 EPILEPSY (SEIZURES)
 FAINTING (FREQUENT)

Yes No
 HEADACHES (FREQUENT)
 HEART VALVE REPLACEMENT
 HEART MUMUR
 HEART ATTACK
 HEART SUGERY
 HEPATITIS (A, B, OR C)
 HERPES
 BLOOD PRESSURE (HIGH/LOW)
 HIVES OR SKIN RASH
 JOINT REPLACEMENT
 KIDNEY DISEASE
 LIVER DISEASE
 MITRO VALVE PROLAPSE
 PACEMAKER
 PSYCHOLOGICAL PROBLEMS
 RADIATION/HEAD/NECK CANCER
 SHORTNESS OF BREATH
 SINUS TROUBLE
 STOMACH/INTESTINAL DISEASE
 STROKE
 SWELLING OF HANDS/FEET
 THYROID DISEASE
 TUBERCULOSIS
 TOBACCO USE
 VENEREAL DISEASE

Yes No
 OTHER MEDICAL CONDITIONS?

 (PLEASE LIST)

Please list any medications that you Are currently taking; including over The counter meds:

Please list any medications that you had an adverse or allergic reaction to:

FOR WOMEN:
 Are you Pregnant? ___ YES ___ # of months ___ NO ___ Not sure
Do you take ?
 Hormones _____ YES _____ NO
 Oral contraceptives _____ YES _____ NO

DENTAL QUESTIONNAIRE:

Who may we thank for referring you to our office? _____

Family Dentist _____ Date of Last Visit _____

Treatment Performed _____

Are you experiencing pain from your mouth at this time? ___ no ___ yes (please explain _____)

Have you had or noticed any of the following? **If yes, please circle:**

Bleeding gums, Loose teeth, Gum recession, Swelling, Sensitive teeth, Shifting of teeth, Uncomfortable chewing, Frequent headaches, Jaw joint pain, Jaw clicking or popping, Fever blisters, Clenching of teeth, Night grinding of teeth, Rough or loose fillings, Mouth odor or bad taste.

How many times have you had your teeth cleaned in the last 5 years? ___ When was the last time? _____

Have you ever had any periodontal treatments? _____ yes _____ no

Please circle if any of the following family member lost their natural teeth: Mother, Father, Brother, Sister

Would you be tremendously disturbed if you had to lose your teeth and wear false teeth? ___ Yes ___ No ___ Maybe

Are you satisfied with the appearance of your teeth? _____ Yes _____ No

What is your main dental concern? _____

What questions do you have regarding periodontal disease? _____

Do you have any dental apprehensions or anxiety that you would like us to know about in order for us to make your care more pleasant? _____

Dental Insurance Information: Ins. Company Name _____ Employer Name _____

Employee Name _____ DOB (if insured is spouse) _____ Social Security Number _____

Insurance and Payment information:

I authorize Lakeland Periodontics, Inc., (Dr. James M Belcher and/or Dr. David Campbell), to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such dental care to third party payers and/or health practitioners. I authorize and hereby request my dental insurance company to pay directly to Lakeland Periodontics my insurance benefits otherwise payable to me. I understand that my dental insurance will not necessarily pay all of the actual billed services. I agree to be responsible for payment of all services rendered on my behalf regardless of insurance coverage or of no insurance coverage. _____ **Please Initial**

Signature of Patient, Parent or Guardian

Date

Signature of Dentist