FROST
PERIODONTICS & DENTAL IMPLANTS

*Health History*

BP: _____ P: _____

It is important that we know about your medical and dental history. Many periodontal conditions and the results of therapy are influenced by your systemic health. **Do you have or have you had any of the following? Please mark all that apply.**

| **General** | **YES** |
|---|---|
| Tire easily, weakness | |
| Marked weight change | |
| Persistent fever | |
| **Skin** | |
| Hives, Rash | |
| Recent noticeable skin changes | |
| **Eyes** | |
| Glaucoma | |
| **Ears** | |
| Ringing in ears | |
| Loss of hearing | |
| **Nose** | |
| Sinus infections | |
| Sinus problems | |
| **Nervous System** | |
| Stroke | |
| Headaches | |
| Convulsions/Epilepsy | |
| Dizziness/Fainting | |
| **Osteoporosis/Osteopenia** | |
| Previous/Current Medication | |
| **Respiratory** | |
| Tuberculosis | |
| Emphysema | |
| Asthma | |
| Hay fever | |
| Cough up blood | |
| Difficulty breathing, reclined | |
| COPD | |
| **Endocrine** | |
| Diabetes T1, T2, Gestational | |
| Family history of Diabetes | |
| Thyroid condition | |
| **Heart/Blood Vessels** | |
| Heart murmur | |
| High blood pressure | |
| Heart attack | |
| Heart surgery | |
| Artificial heart valve | |
| Chest pain/angina | |
| Atrial fibrillation | |
| Pacemaker | |
| Congenital heart disease | |
| Rheumatic fever | |
| **Musculoskeletal System** | |
| Bone/muscles | |
| Arthritis/rheumatism | |
| Artificial joints/limbs | |
| **Digestive System** | |
| Ulcers | |

| **Urinary/Liver** | **YES** |
|---|---|
| Kidney disease | |
| Frequent urination | |
| Burning on urination | |
| Untreated STD | |
| Hepatitis A B C | |
| **Blood** | |
| Bruise easily | |
| Anemia | |
| Blood transfusion | |
| **Other** | |
| Cancer | |
| Cancer of/in bone | |
| Tumors or growths | |
| Radiation therapy | |
| Chemotherapy | |
| HIV Positive | |
| **Allergies to:** | |
| Local anesthetics | |
| Sedatives/sleeping pills | |
| Penicillin | |
| Other antibiotics | |
| Codeine | |
| Sulfa drugs | |
| Other: _____ | |
| **Are you taking any of the following?** | **YES** |
| Prescription (Rx) medicine | |
| Non-Rx medicine | |
| Herbal medicine | |
| Recreational drugs | |
| **List medications below:** | |
| 1. | |
| 2. | |
| 3. | |
| 4. | |
| 5. | |

**Do you consume >2 alcoholic beverages per day? (circle)**
Yes No

**Do you need to premedicate for dental visits?**
Yes No

**Have you OR do you currently use tobacco products?**
Yes No
Type/Amt: _____

**Are you pregnant? (circle)**
Yes No
Due Date: _____

**Have you ever been told you cannot donate blood? (circle)**
Yes No

| **Dental History** | |
|---|---|
| **Does dental treatment make you nervous? (circle)** No Slightly Moderate Severe | |
| **Do you have any of the following?** | **YES** |
| Bleeding gums | |
| Bad breath | |
| Burning lips/tongue | |
| Oral swelling | |
| Frequent fever blisters/cold sores | |
| Frequent canker sores | |
| Biting cheeks/lips | |
| TMJ | |
| Clicking/popping jaw | |
| Difficulty opening or closing jaw | |
| Loose teeth | |
| Teeth sensitive to cold | |
| Teeth sensitive to hot | |
| Teeth sensitive to sweets | |
| Food impaction | |
| Shifting of teeth | |
| Change in bite | |
| Sensitivity when biting | |
| Have you ever been treated for gum disease? | |
| Have you ever had gum surgery? | |
| **Oral Hygiene Practices Which do you use daily?** | |
| Brush | |
| Floss | |
| Interdental/proxabrush | |
| Electric toothbrush | |
| Mouthwash | |

**Are you happy with the appearance of your teeth? (circle)**
Yes No

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any changes in my health or change in my medication, I will inform my doctor at the next appointment.

X_____

Signature of Patient/Parent/Guardian

***Authorization*** **Doctor Signature:** _____ **Date:** _____

I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. In the event that the insurance carrier pays less than the estimated amount, I understand that I am responsible for the unpaid balance. Accounts not paid within arranged terms are subject to a 16% annual finance charge and late fee up to $10.

**Signature:** **Date:**

**Payment is expected at time of treatment unless prior arrangements have been approved.**