PERIO SPECIALIST
oral care beyond teeth®

NEW PATIENT REGISTRATION

PATIENT INFORMATION

First Name | Last Name | Date of Birth | Gender

Mobile Phone # | Email

Address

Emergency Contact Name | Emergency Contact Phone #

PREFERRED PHARMACY

Pharmacy Name | Pharmacy Phone

Address

DENTAL HISTORY

How fearful are you of dental treatment (10 being the most)?

Have you ever had braces, or had your bite adjusted? ☐Yes ☐No

Have you ever had gum surgery? ☐Yes ☐No

Have you ever had deep cleaning of your teeth? ☐Yes ☐No

Do you have any dental implants in your mouth? ☐Yes ☐No

Date of last deep cleaning

POLICY HOLDER

Insured First Name | Insured Last Name

Relation to Patient | Gender

Insured Social Security | Date of Birth

INSURANCE INFORMATION

Insurance Name

Policy ID | Ins Phone Number

Group # | Group Name

Address

☐ I certify I have read and I understand the questions. I acknowledge my questions have been answered to my satisfaction. I will not hold my doctor, or any other member of his/her team, responsible for any errors or omissions that I have made in the completion of this form. I also agree to the use of AI-enabled devices to record and transcribe clinical documentation, with my information handled according to the practice's privacy policies.

☐ I agree to receive SMS updates at the phone number provided above and understand that message frequency may vary. Msg & data rates may apply. Reply STOP to opt out.

☐ If I have dental insurance, my signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

☐ I hereby acknowledge a copy of the Notice of Privacy Practices has been made available to me (see form on website). I have been given the opportunity to ask any questions I may have regarding this Notice.

MEDICAL HISTORY

Patient Name: Birth Date:

Are you in good health? ☐Yes ☐No Height _____ Weight _____ Are you under care of a physician? ☐Yes ☐No

Are you currently taking or planning to take antibiotics before dental treatment? ☐Yes ☐No

Have you been hospitalized in the past five years? ☐Yes ☐No Have you ever had general anesthesia? ☐Yes ☐No

Have you or your family had reactions to general anesthesia? ☐Yes ☐No Have you had the COVID vaccination? ☐Yes ☐No

Are you taking, or have you ever taken bone density meds, RANKL inhibitors or bisphosphonates such as Denosumab, Fosamax, Boniva, Actonel, IV-Zometa, Aredia, Reclast, Prolia, Xgeva, or Evista in the past 12 years? ☐Yes ☐No

WOMEN ONLY

1-4 below for women only: (Note: antibiotics, such as penicillin, may alter the effectiveness of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of birth control.)

1) Is there a possibility of pregnancy? ☐Yes ☐No 2) Expected delivery date _____

3) Are you nursing? ☐Yes ☐No 4) Are you taking birth control pills? ☐Yes ☐No

ALLERGIES/REACTIONS

Y	N		Y	N		Y	N		Y	N	
☐	☐	Penicillin	☐	☐	Sulfa drugs	☐	☐	Local anesthetic	☐	☐	Amoxicillin
☐	☐	Aspirin	☐	☐	Codeine or other narcotics	☐	☐	Latex	☐	☐	Do you have any known allergies

Please list any allergies not listed above _____

MEDICAL CONDITIONS

Do you have, or have you had, any of the following diseases, medical conditions, or procedures?

Y	N		Y	N		Y	N		Y	N	
☐	☐	AIDS / HIV	☐	☐	Dementia	☐	☐	High blood pressure	☐	☐	Prosthetic implant
☐	☐	Alzheimer's	☐	☐	Diabetes	☐	☐	High cholesterol	☐	☐	History of Radiation
☐	☐	Anemia	☐	☐	Do you smoke or vape	☐	☐	History of alcohol / drug abuse	☐	☐	Respiratory problems
☐	☐	Arthritis / Joint disease	Number of smoke/day_____			☐	☐	History of marijuana / drug use	☐	☐	Rheumatic fever
☐	☐	Asthma	☐	☐	Do you use chewing tobacco	☐	☐	Infectious mononucleosis	☐	☐	Sexually transmitted diseases
☐	☐	Bleeding tendency	☐	☐	Emphysema	☐	☐	Irregular heart beat	☐	☐	Sleep apnea / CPAP
☐	☐	Blood transfusion	☐	☐	Eye disease / Glaucoma	☐	☐	Joint replacement	☐	☐	Special diet
☐	☐	Bronchitis	☐	☐	Fainting spells	☐	☐	Kidney trouble	☐	☐	Stomach ulcers / acid reflux
☐	☐	Bruise easily	☐	☐	Hay fever / Sinus problems	☐	☐	Liver disease	☐	☐	Stroke
☐	☐	Cancer	☐	☐	Heart attack(s)	☐	☐	Low blood pressure	☐	☐	Thyroid trouble
☐	☐	Chest pain / Angina	☐	☐	Heart murmur	☐	☐	Low blood sugar	☐	☐	Trouble climbing 1-2 flights of stairs
☐	☐	Chronic cough	☐	☐	Heart pacemaker	☐	☐	Mental health problems	☐	☐	Tumor or growth
☐	☐	Chronic fatigue / Night sweat	☐	☐	Heart surgery	☐	☐	Osteopenia			
☐	☐	Convulsions / Epilepsy	☐	☐	Heart trouble	☐	☐	Osteoporosis			
☐	☐	COVID–19	☐	☐	Heart valve issues	☐	☐	Pneumonia			
☐	☐	Delay in healing	☐	☐	Hepatitis	☐	☐	Problems with immune system			

Any other medical conditions not listed above _____

MEDICATIONS

Please list any other medication(s) you are taking (including natural, herbal, or homeopathic products):

Medication Name	Dosage	Frequency	Medication Name	Dosage	Frequency

PATIENT SIGNATURE

X **X**

Signature of patient **Date**

DOCTOR'S NOTES

X **X**

Signature of dentist **Date**