David Anson, D.D.S.

Periodontal and Implant Reconstruction

This information is requested in order that we may thoroughly diagnose and treat your condition and will be held in strict confidence.

Email_____

Date_____

Name_____ Soc.Sec.Number_____

Ht._____ Weight_____ Marital Status_____ Age_____ Date of Birth_____

Residence Address_____ City_____ Zip_____ Res.Tel._____

Business Address_____ Zip_____ Bus.Tel._____

Your Occupation_____ Cell.Tel. _____

Dentist_____ Address_____ Tel.(__)_____ Yrs._____

Physician_____ Address_____ Tel.(__)_____ Yrs._____

Whom may we thank for referring you?_____ _____

Emergency Contact (First Name, Last Name & Telephone number_____

YOUR HEALTH HISTORY

Are you allergic to Latex? Y☐ N☐

Are you currently under a physician's care?.....YES☐NO☐

Are you currently taking any drugs or medications?.....YES☐NO☐

IF YES, PLEASE LIST:_____

_____

IT IS IMPORTANT THAT ALL MEDICATIONS AND DRUGS USED ARE LISTED AS SOME MEDICATIONS AND DRUGS INTERACT WITH LOCAL ANESTHETIC.

Have you ever had any unusual reaction to any drug or anesthetic?.....YES☐NO☐

Have you ever had excessive bleeding requiring special treatment?.....YES☐NO☐

Do you smoke? YES☐NO☐ How much?_____ For how long?_____

Have you been hospitalized in the past five years?.....YES☐NO☐

Do you have any prosthetic devices? (heart valve, joints, pacemaker, etc.).....YES☐NO☐

Do you have or have you ever had any of the following? If so, please circle.

☐**Heart Murmur or Problem**	☐**Thyroid Problem**	☐ **Psychiatric Treatment**	☐ **Asthma**
☐**Hepatitis or Liver Disease**	☐**H.I.V. Positive**	☐ **Alcoholism**	☐ **Allergies**
☐**Kidney or Bladder Problem**	☐ **Ulcers**	☐**Convulsions or Seizures**	☐ **Diabetes**
☐**Glaucoma or Eye Disease**	☐**High Blood Pressure**	☐ **Stroke**	

Are you now, or have you ever taken a Bisphosphonate medication, including any injectable ones or infusions? (e.g. Fosomax, Boniva, Zometa etc...) .....YES☐NO☐

Is there any additional information about your health that we should know?.....YES☐NO☐

If so, please list:_____

WOMEN: Are you pregnant? YES☐NO☐ Have you passed menopause?.....YES☐NO☐

YOUR ORAL HEALTH HISTORY

Date of your last dental cleaning appointment_____

Do you have any condition in your mouth causing you pain or discomfort?.....YES☐NO☐

Have you had any shifting or movement of your teeth lately?.....YES☐NO☐

Do you clench or grind your teeth during the day or night?..... YES☐NO☐

Does your jaw click when you chew?.....YES☐NO☐

Have you ever had any periodontal treatment on your gums?.....YES☐NO☐

YOUR DENTAL BENEFIT INFORMATION

Employer_____ Dental Ins. Co._____ Policy #_____

Spouse Employer_____ Dental Ins. Co._____ Policy # _____

Name of Spouse_____ Spouse SS#:_____

Spouse Date of Birth_____ Which is your primary insurance?_____

Signature of Patient_____ Date_____

(or authorized person if patient is minor)