

# Premier Periodontics

Bellevue | Kirkland | Mercer Island | Redmond | Everett



PATIENT PERSONAL INFORMATION										
Today's date:			Date reviewed/updated:				Initial here _____			
Title:	Last name:		First:	Middle:	Nickname:		Birth date:		Age:	
Address:					Cell Phone:		Marital Status:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F		
City, State, Zip:			Home Phone:			Work Phone:				
E-mail:				Emergency Contact:						
PATIENT MEDICAL INFORMATION										
Check yes or no:										
<b>Allergies:</b>										
Penicillin	<input type="checkbox"/> Y	<input type="checkbox"/> N	Local Anesthetics		<input type="checkbox"/> Y	<input type="checkbox"/> N	Iodine	<input type="checkbox"/> Y	<input type="checkbox"/> N	
Sulfa Drugs	<input type="checkbox"/> Y	<input type="checkbox"/> N	Aspirin		<input type="checkbox"/> Y	<input type="checkbox"/> N	Latex Rubber	<input type="checkbox"/> Y	<input type="checkbox"/> N	
Erythromycin	<input type="checkbox"/> Y	<input type="checkbox"/> N	Codeine		<input type="checkbox"/> Y	<input type="checkbox"/> N				
<b>Other Allergies:</b>										
Kidney Disease	<input type="checkbox"/> Y	<input type="checkbox"/> N	Arthritis		<input type="checkbox"/> Y	<input type="checkbox"/> N	Stroke		<input type="checkbox"/> Y	<input type="checkbox"/> N
Alcohol/Drug Abuse	<input type="checkbox"/> Y	<input type="checkbox"/> N	Rheumatic Fever		<input type="checkbox"/> Y	<input type="checkbox"/> N	Heart Attack		<input type="checkbox"/> Y	<input type="checkbox"/> N
Congestive Heart Failure	<input type="checkbox"/> Y	<input type="checkbox"/> N	AIDS/HIV Infection		<input type="checkbox"/> Y	<input type="checkbox"/> N	Blood Transfusion		<input type="checkbox"/> Y	<input type="checkbox"/> N
Blood Clotting Problems	<input type="checkbox"/> Y	<input type="checkbox"/> N	Rheumatic Heart Disease		<input type="checkbox"/> Y	<input type="checkbox"/> N	Heart Murmur		<input type="checkbox"/> Y	<input type="checkbox"/> N
Emphysema	<input type="checkbox"/> Y	<input type="checkbox"/> N	Angina/Chest Pain		<input type="checkbox"/> Y	<input type="checkbox"/> N	Cardiac Pacemaker		<input type="checkbox"/> Y	<input type="checkbox"/> N
Hives	<input type="checkbox"/> Y	<input type="checkbox"/> N	CPAP User		<input type="checkbox"/> Y	<input type="checkbox"/> N	Diabetes		<input type="checkbox"/> Y	<input type="checkbox"/> N
Tuberculosis	<input type="checkbox"/> Y	<input type="checkbox"/> N	Stomach Ulcers		<input type="checkbox"/> Y	<input type="checkbox"/> N	Anemia		<input type="checkbox"/> Y	<input type="checkbox"/> N
Mitral Valve Prolapse	<input type="checkbox"/> Y	<input type="checkbox"/> N	Sleep Apnea		<input type="checkbox"/> Y	<input type="checkbox"/> N	Bulimia		<input type="checkbox"/> Y	<input type="checkbox"/> N
High Blood Pressure	<input type="checkbox"/> Y	<input type="checkbox"/> N	Fainting Spells		<input type="checkbox"/> Y	<input type="checkbox"/> N	Asthma		<input type="checkbox"/> Y	<input type="checkbox"/> N
Cancer/Tumor or Growth	<input type="checkbox"/> Y	<input type="checkbox"/> N	Bronchitis		<input type="checkbox"/> Y	<input type="checkbox"/> N	Thyroid Problems		<input type="checkbox"/> Y	<input type="checkbox"/> N
Frequent Headaches	<input type="checkbox"/> Y	<input type="checkbox"/> N	Sinus Trouble		<input type="checkbox"/> Y	<input type="checkbox"/> N	Lupus		<input type="checkbox"/> Y	<input type="checkbox"/> N
Shortness of Breath	<input type="checkbox"/> Y	<input type="checkbox"/> N	Joint Replacement		<input type="checkbox"/> Y	<input type="checkbox"/> N	Seizures		<input type="checkbox"/> Y	<input type="checkbox"/> N
Radiation/Chemo-therapy	<input type="checkbox"/> Y	<input type="checkbox"/> N	Dry Mouth/Sjogren		<input type="checkbox"/> Y	<input type="checkbox"/> N	Gag Reflex		<input type="checkbox"/> Y	<input type="checkbox"/> N
Cardiovascular/Heart Disease	<input type="checkbox"/> Y	<input type="checkbox"/> N	Do you Pre-Medicate with Antibiotic?		<input type="checkbox"/> Y	<input type="checkbox"/> N	Hay Fever		<input type="checkbox"/> Y	<input type="checkbox"/> N
Hepatitis: A, B or C	<input type="checkbox"/> Y	<input type="checkbox"/> N	Sexually Transmitted Disease		<input type="checkbox"/> Y	<input type="checkbox"/> N				
Have you had any serious illnesses, operations, been hospitalized in the last 5 years or any other medical issues or concerns not listed above?										
Please List All Medications:										
Have you taken bisphosphonates? (Fosamax, Boniva, Zometa, Actonel, Didronel, Aredia, Skelid, Reclast) <input type="checkbox"/> Y <input type="checkbox"/> N										

**BY SIGNING BELOW, I CERTIFY THAT ALL OF THE ABOVE INFORMATION IS TRUE AND TO THE BEST OF MY KNOWLEDGE.**

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Date