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: ☐ M ☐ F
City, State, Zip:	Home Phone:			Work Phone:		
E-mail:	Emergency Contact:					

PATIENT MEDICAL INFORMATION								
Check yes or no:								
Allergies:								
Penicillin	Y ☐ N ☐		Local Anesthetics	Y ☐ N ☐		Iodine	Y ☐ N ☐	
Sulfa Drugs	Y ☐ N ☐		Aspirin	Y ☐ N ☐		Latex Rubber	Y ☐ N ☐	
Erythromycin	Y ☐ N ☐		Codeine	Y ☐ N ☐				
Other Allergies:								
Kidney Disease	Y ☐ N ☐		Arthritis	Y ☐ N ☐		Stroke	Y ☐ N ☐	
Alcohol/Drug Abuse	Y ☐ N ☐		Rheumatic Fever	Y ☐ N ☐		Heart Attack	Y ☐ N ☐	
Congestive Heart Failure	Y ☐ N ☐		AIDS/HIV Infection	Y ☐ N ☐		Blood Transfusion	Y ☐ N ☐	
Blood Clotting Problems	Y ☐ N ☐		Rheumatic Heart Disease	Y ☐ N ☐		Heart Murmur	Y ☐ N ☐	
Emphysema	Y ☐ N ☐		Angina/Chest Pain	Y ☐ N ☐		Cardiac Pacemaker	Y ☐ N ☐	
Hives	Y ☐ N ☐		CPAP User	Y ☐ N ☐		Diabetes	Y ☐ N ☐	
Tuberculosis	Y ☐ N ☐		Stomach Ulcers	Y ☐ N ☐		Anemia	Y ☐ N ☐	
Mitral Valve Prolapse	Y ☐ N ☐		Sleep Apnea	Y ☐ N ☐		Bulimia	Y ☐ N ☐	
High Blood Pressure	Y ☐ N ☐		Fainting Spells	Y ☐ N ☐		Asthma	Y ☐ N ☐	
Cancer/Tumor or Growth	Y ☐ N ☐		Bronchitis	Y ☐ N ☐		Thyroid Problems	Y ☐ N ☐	
Frequent Headaches	Y ☐ N ☐		Sinus Trouble	Y ☐ N ☐		Lupus	Y ☐ N ☐	
Shortness of Breath	Y ☐ N ☐		Joint Replacement	Y ☐ N ☐		Seizures	Y ☐ N ☐	
Radiation/Chemo-therapy	Y ☐ N ☐		Dry Mouth/Sjogren	Y ☐ N ☐		Gag Reflex	Y ☐ N ☐	
Cardiovascular/Heart Disease	Y ☐ N ☐		Do you Pre-Medicate with Antibiotic?	Y ☐ N ☐		Hay Fever	Y ☐ N ☐	
Hepatitis: A, B or C	Y ☐ N ☐		Sexually Transmitted Disease	Y ☐ N ☐				

Have you had any serious illinesses, operations, been hospititalized 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) Y ☐ 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