NORTH BROWARD
CENTER FOR
LASER PERIODONTICS AND IMPLANTS

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Today's Date_____

PATIENT INFORMATION:

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. First Name : _____ M.I.:____ Last Name: _____

Sex: ❑ Male ❑ Female Birth Date: _____ Age: _____ Soc. Sec. #: _____ E-mail: _____

Address: _____ Apt.: _____ City: _____ State: _____ Zip: _____

Phone #: ( ) _____ Alternate Phone #: ( ) _____ Driver's License #: _____

Employer: _____ Emp. Phone #: ( ) _____

Dentist: _____ Medical Doctor: _____ Orthodontist: _____

Have you ever been a patient of our practice? ❑ Yes ❑ No Referred By: _____

Nearest relative not living with you: _____ Phone # ( ) _____

MINORS ONLY:

Since the patient is a MINOR (under 18 years of age), I agree that I will be responsible for his / her account and that the following information is accurate.

I am the patient's: ❑ Father ❑ Mother ❑ Spouse ❑ Other: _____

Name: _____ Birth Date: _____ Age: ____ Phone #: ( ) _____

Address: _____ Apt.: _____ City: _____ State: _____ Zip: _____

E-mail: _____ Soc. Sec. #: _____

Employer: _____ Emp. Phone #: ( ) _____

PATIENT'S HEALTH HISTORY:

Reason for today's office visit? _____

		Yes	No
1.	***Height:*** _____ ***Weight:*** _____ Are you in good health?	❑	❑
2.	Have there been any changes in your general health in the past year?	❑	❑
3.	Are you under the care of a physician? ***Date of last visit:*** _____	❑	❑
	If so, for what are you being treated? _____		
4.	Have you had any illness, or been hospitalized in the past five years?	❑	❑
	If so, describe: _____		
5.	Do you have unhealed / recurrent injuries or inflamed areas, growths or sore spots in or around your mouth?	❑	❑
	If so, describe where: _____		
6.	Do you have a prosthetic joint / implant? ***If so, describe where:*** _____	❑	❑
7.	Have you had a heart valve replacement or vascular graft?	❑	❑
8.	Have you, or a family member, had any unusual or serious reactions to general anesthesia (ex: Malignant Hyperthermia)?	❑	❑
9.	Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	❑	❑
10.	Is there any condition concerning your health that the Doctor should be told about?	❑	❑
	If so, describe: _____		
11.	Do you wish to speak to the Doctor privately about anything?	❑	❑
12.	If you would like to have surgery today, have you had anything to eat or drink (including water) in the last 6 (six) hours?	❑	❑
	Who will be driving you home: _____ ***Phone #: (***) _____		

HAVE YOU HAD, OR DO YOU CURRENTLY HAVE:	YES	NO	NOTES
13. Rheumatic fever?			
14. Damaged heart valves / mitral valve prolapse?			
15. Heart murmur?			
16. High blood pressure?			
17. Low blood pressure?			
18. Chest pain / angina?			
19. Heart attack(s)?			
20. Irregular heart beat?			
21. Cardiac pacemaker?			
22. Heart surgery?			
23. Pneumonia, bronchitis, chronic cough?			
24. Asthma?			
25. Hay fever / sinus problems?			
26. Snoring?			
27. Sleep apnea / CPAP?			
28. Difficult breathing / other lung trouble?			
29. Tuberculosis?			
30. Emphysema?			
31. Do you smoke? If so, # of packs a day: _____ , years_____			
32. Do you consume alcoholic beverages? If so, how many per day: _____			
33. Do you use chewing tobacco?			
34. Blood transfusion?			
35. Blood disorder such as anemia?			
36. Bruise easily?			
37. Bleeding tendency / abnormal bleeding?			
38. Hepatitis, jaundice, or liver disease?			
39. Infectious mononucleosis?			
40. Gallbladder trouble?			
41. Convulsions / epilepsy / fainting spells?			
42. Stroke?			
43. Thyroid trouble?			
44. Diabetes?			
45. Low blood sugar?			
46. Kidney trouble?			
47. High cholesterol?			
48. Are you on dialysis?			
49. Swollen ankles / arthritis / joint disease?			
50. Osteoporosis / osteopenia / rheumatoid arthritis?			
51. Osteonecrosis?			
52. Stomach ulcers / acid reflux?			
53. HIV / AIDS?			
54. Sexually transmitted diseases?			
55. Problems with immune system?			
56. Delay in healing?			
57. A tumor or growth?			
58. Cancer / radiation therapy / chemotherapy?			
59. Chronic fatigue / night sweats?			
60. Are you on a diet?			

HAVE YOU HAD, OR DO YOU CURRENTLY HAVE:	YES	NO	NOTES
61. A history of alcohol abuse?			
62. A history of drug abuse?			
63. Contact lenses?			
64. Eye disease / glaucoma?			
65. Mental health problems / anxiety / depression?			
66. Pain or clicking of jaws when eating?			

HAVE YOU EVER TAKEN, OR ARE YOU CURRENTLY TAKING:	YES	NO	NOTES
67. Any medication, drug, pills?			
68. Any natural product, herbal supplement or homeopathic remedy?			
69. Diet pills?			

70. Anti-angiogenic medication *(examples: Avastin, Bevacizumab, Endostatin)*? If so, please list:

71. Bisphosphonate medication *(examples: Aredia, Zometa, Reclast, Fosamax, Actonel, Boniva)*? If so, please list:

72. Blood thinners *(examples: Coumadin, Plavix, Aspirin, Vitamin E, Ginko biloba, Aggrenox, Pradaxa, Fish oil)*? If so, please list:

73. Tranquilizers, sleeping pills, anti-depressants, and/or narcotics on a regular basis? If so, please list:

74. Please list any medications you are currently taking:

Medication	Dosage	Frequency

ARE YOU ALLERGIC TO, OR HAD A REACTION TO:	YES	NO	NOTES
75. Amoxicillin?			
76. Aspirin?			
77. Codeine or other narcotics?			
78. Eggs / yolk?			
79. Latex?			
80. Local anesthetic (numbing meds.)?			
81. Other antibiotics?			
82. Penicillin?			
83. Sodium pentothal / Valium /other tranquilizers?			
84. Soy?			
85. Sulfa drugs?			
86. Sulfites?			

87. Please list any other medication or antibiotic you are allergic to:

88. Please list any allergies other than drug allergies:

SURGERIES:

	Yes	No
89. Have you ever had sedation or general anesthesia?	❑	❑
90. Have you had any surgeries in the past?	❑	❑
If so, describe: _____		
91. Have you had any complications and / or problems with any of your surgeries or the anesthesia provided?	❑	❑
If so, describe: _____		

IS THERE A FAMILY HISTORY OF:

	Yes	No		Yes	No
92. Cancer?	❑	❑	95. Anesthesia Problems?	❑	❑
93. Diabetes?	❑	❑	96. Malignant Hyperthermia?	❑	❑
94. Heart Disease?	❑	❑			

WOMEN ONLY: *(QUESTIONS 97–100)*

	Yes	No		Yes	No
97. Is there a possibility of pregnancy?	❑	❑	99. Are you nursing?	❑	❑
98. Expected delivery date? _____			100. Are you taking birth control pills?	❑	❑

Note: *Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician / gynecologist for assistance regarding other methods of birth control.*

EMERGENCY CONTACT:

Name: _____ Phone #: (_____) _____

INSURANCE INFORMATION:

I currently have the following dental insurance: ❑ I do not have insurance

Insured's Name: _____ Relation to patient: _____
Insurance company's Name: _____ Insurance company's Phone Number: _____
Insured's SSN or member ID: _____ Insured's date of birth: _____
Insured's Employer: _____ Group Number: _____

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his / her staff, responsible for any errors or omissions that I have made in the completion of this form.

X _____ **X** _____ **X** _____ **X** _____
Signature of patient *(Parent or Guardian if Minor)* **Date** **Reviewed by / Doctor signature** **Date**

AUTHORIZATION

I authorize my surgeon and his / her designated staff, to perform an oral and maxillofacial examination, for the purpose of diagnosis and treatment planning. Furthermore, I authorize the taking of all x–rays required as a necessary part of this examination. In addition, if medically necessary, I authorize the release of any information acquired in the course of my examination and treatment to my other doctors and/or insurance carriers.

X _____ **X** _____
Signature of patient *(Parent or Guardian if Minor)* **Date**

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

X _____ **X** _____
Signature of patient *(Parent or Guardian if Minor)* **Date**