Laser Implant Periodontal
SPECIALIST

New Patient Information Form & Medical History

PERSONAL INFORMATION:

Name:_____ Birth date (D/M/Y):_____

Phone:_____Cell:_____Work:_____

Address:_____ Postal Code: _____

Email: _____ Dentist:_____

Emergency Contact Name: _____Phone:_____

MEDICAL INFORMATION:

List any drugs or homeopathic medications being taken & purpose: (ie Aspirin, Blood Thinners)

DRUG Purpose

_____

_____

List Allergies or Drug Sensitivities: (ie Penicillin or Aspirin)

_____

Please circle or check any of the following that are applicable:

* HIV/AIDS	* Glaucoma	* Fainting or Dizziness	* Bruise Easily	* Bleeding Gums
* Asthma	* Stroke	* Anemia	* Anxiety	* Tooth Pain
* Tuberculosis	* Pacemaker	* Cancer Past/Present	* Jaundice	* Loose/Moving Teeth
* Rheumatic Fever	* Ulcers	* Radiation Therapy	* Excessive Urination	* Cold Sores
* Heart Murmur	* Arthritis	* Chemotherapy	* Shortness of Breath	* TMJ Pain
* Heart Disease	* Diabetes Type I or II	* Osteoporosis	* Pregnant	* Bleeding Gums
* Emphysema	* Artificial Joints	* Severe Headaches	* Menopause	* Food Impaction
* Hepatitis A/B/C	* Epilepsy/Seizures	* Abnormal Stress	* Taking Estrogen	* Dry Mouth or Bad Breath
* Past/Present Smoker	* Pre Medication	* Prolonged Cough	* Skin rash/Psoriasis	* Difficulty Swallowing
* High/Low Blood Pressure	* Kidney/Bladder/ Gallbladder Disease	* Hypo/Hyper Thyroid Disease	* High/Low Cholesterol	* Nightguard - Do you wear it? Yes/No

Do you have any concerns regarding your visit today or any past dental experiences? _____

What is your understanding of the nature of your visit today? _____

TO THE BEST OF MY KNOWLEDGE ALL OF THE ABOVE ANSWERS ARE TRUE AND CORRECT, IF I HAVE ANY CHANGES IN MY HEALTH, I WILL INFORM DR. DESAI AND HER STAFF AT MY NEXT APPOINTMENT. I ALSO UNDERSTAND THAT THE COSTS ENTAILED IN TODAY'S CONSULTATION AND XRAY IMAGES NECESSARY WILL BE PAID ON THE SAME DAY. I ALSO CONSENT TO THE TAKING OF INTRAORAL PHOTOS OF PRE AND POST SURGICAL PROCEDURES FOR DOCUMENTATION PURPOSES IN MY FILE.

Patient Signature Date

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