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/vitamins being\ taken & purpose: (ie Aspirin, Blood Thinners, etc)

*DRUG* *Purpose*

_____

_____

If on blood thinners (ie Aspirin) What is your INR # & date of last test: _____

List Allergies or Drug Sensitivities: (ie Antibiotics, pain medication)

_____

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

| | | | | |
|---|---|---|---|---|
| * HIV/AIDS | * Glaucoma | * Fainting or Dizziness | * Bruise Easily | * Past/Present Smoker |
| * Asthma | * Stroke | * Anemia | * Anxiety | * Tooth Pain |
| * Tuberculosis | * Pacemaker | * Cancer (Past/Present) | * Jaundice | * Loose/Moving Teeth |
| * COPD/Lung Disease | * Ulcers | * Radiation Therapy | * Excessive Urination | * Cold Sores |
| * Heart Murmur | * Arthritis | * Chemotherapy | * Shortness of Breath | * TMJ Pain |
| * Heart Disease | * High/Low Cholesterol | * Osteoporosis | * Pregnant | * Bleeding Gums |
| * Pre Medication | * Artificial Joints | * Severe Headaches | * Menopause | * Food Impaction |
| * Hepatitis A/B/C | * Epilepsy/Seizures | * Abnormal Stress | * Taking Estrogen | * Dry Mouth or Bad Breath |
| * Rheumatic Fever | * Emphysema | * Prolonged Cough | * Skin rash/Psoriasis | * Difficulty Swallowing |
| * High/Low Blood Pressure | * Kidney/Bladder/ Gallbladder Disease | * Hypo/Hyper Thyroid Disease | * Diabetes Type I or II Hb A1C #: | * Nightguard - Yes/No 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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