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** 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

Are you vaccinated for COVID-19? **YES / NO** Date of last vaccine: ______________________

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.

Name **Signature** **Date**

____________________ ____________________ ____________________

e: desaireception@gmail.com A 101-775 McGill Road , Kamloops, BC V2C 0B8 T 778-471-6001 F 778-471-6002
W www.kamloopsperiodontist.com