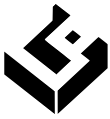

Columbia Periodontal
ASSOCIATES
Periodontal and Implant Dentistry

William B. Farrar, DDS
J. Lee Ayers, Jr., DMD, MHS

PATIENT INFORMATION

Today's Date____________________

Patient's Name: ________________________________Title: ________ Date of Birth: ____________
Residence Street: ____
City/State/Zip: ____Email: ____________________
Home Telephone: ________________ Work Telephone: ______________ Cell Phone: ____________________
Patient Employed By: ____________________________________ Occupation: ______________________
Business Address: ____
Patient's Social Security #: ______________________ Spouse's Social Security #: ____________________
Spouse's Name: ____________________________________ Spouse's Date of Birth__________________
Spouse Employed By: ____________________________________ Occupation: ____________________
Business Address: ____
Person Responsible for Account: ____
Dental Insurance: ____Policy Number: ____________________
Insurance Address: ______________________________________ Telephone #: ____________________

DENTAL HISTORY

1. Do you have any unhealed injuries or inflamed areas in or around your mouth? ❑Yes ❑No
2. Do you have any growths or sore spots in your mouth? ❑Yes ❑No
3. Do you chew on only one side of your mouth? ❑Yes ❑No
4. Do you have any pain in or near your ears? ❑Yes ❑No
5. Do you habitually clench your teeth during the day or night? ❑Yes ❑No
6. Is any part of your mouth sore to clenching? ❑Yes ❑No
7. Is any part of your mouth sore to pressure? ❑Yes ❑No
8. Are your teeth sensitive to hot, cold, or sweets? (Circle which, if any) ❑Yes ❑No
9. Do your gums bleed? ❑Yes ❑No
10. Have you ever been instructed in caring for your gums? ❑Yes ❑No
11. Do you have any present dental complaints? ❑Yes ❑No
12. Approximate date of last dental examination? __________
13. Was all dental treatment completed? ❑Yes ❑No
14. Date teeth were cleaned? __________

MEDICAL HISTORY

1. Has there been any change in your general health within the last year? ❑Yes ❑No
2. When was your last physical examination? __________
3. Are you under the care of a physician? If yes, for what reason?__________ ❑Yes ❑No
____
____
4. Have you had any serious illness or operation? If so, what?__________ ❑Yes ❑No
____

(see other side)

5. Do you have or have you had any of the following conditions? ❑Yes ❑No
(check if any)
❑Rheumatic Fever
❑Rheumatic Heart Disease
❑Heart Murmur / Mitral Valve Prolapse
❑Cardiovascular Disease / Heart Disease
❑High Blood Pressure
❑Heart Attack
❑Stroke
❑Congenital Heart Lesions
❑Artificial Valves / Joints

6. After mild exercise, do you have pain in your chest, or are you short of breath? ❑Yes ❑No

7. Do you get short of breath when you lie down, or do you require extra pillows when you sleep? ❑Yes ❑No

8. Anxiety? ❑Yes ❑No

9. Asthma? ❑Yes ❑No

10. Sinus Trouble or Hay Fever? ❑Yes ❑No

11. Seizures or Fainting Spells? ❑Yes ❑No

12. Diabetes? ❑Yes ❑No

Does anyone in your family have diabetes? ❑Yes ❑No

Do you have to go to the restroom more than six times each day? ❑Yes ❑No

Are you thirsty much of the time? ❑Yes ❑No

13. Hepatitis, Jaundice or Liver Disease? ❑Yes ❑No

14. Arthritis? ❑Yes ❑No

15. Stomach Ulcers? ❑Yes ❑No

16. Tuberculosis? ❑Yes ❑No

17. Venereal Disease? ❑Yes ❑No

18. Have you been exposed to H.I.V. / A.I.D.S.? ❑Yes ❑No

19. Have you tested positive for H.I.V. / A.I.D.S.? ❑Yes ❑No

20. Have you ever been advised to take antibiotics prior to dental work? If yes, what were you prescribed? __________
________________________________ ❑Yes ❑No

21. Do you use tobacco? (check, if any) ❑Yes ❑No
❑Pipe ❑Snuff
❑Cigars ❑Cigarettes

22. Have you ever had excessive bleeding from a cut? ❑Yes ❑No

23. Do you bruise easily? ❑Yes ❑No

24. Do you have any blood disorder such as anemia? ❑Yes ❑No

25. Do you take aspirin daily? ❑Yes ❑No

26. Are you taking any drugs, medicine or pills prescribed by a doctor or over the counter? (If so, what drugs?) ❑Yes ❑No
____
____
____
____

27. Are you allergic or have you reacted adversely to: (check, if any) ❑Yes ❑No
❑Local Anesthetics ❑Latex
❑Penicillin ❑Other Antibiotics
❑Codeine ❑Demerol
❑Aspirin ❑Any other drugs
❑Barbiturates, Sedatives or Sleeping Pills

28. Are you taking or have you taken any medications for the treatment of osteoporosis such as Fosamax, Actonel, or Boniva? ❑Yes ❑No

29. <u>Women:</u> Do you take birth control pills? ❑Yes ❑No
Are you pregnant? ❑Yes ❑No

Your General Dentist's Name: ______________________ Your Medical Doctor's Name: ______________________

Patient's Signature: ________________________________ Date: ______________

Medical / Dental History Reviewed By: ________________________________