Laser Implant Periodontal
SPECIALIST

Patient Information & Medical History

PERSONAL INFORMATION:

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

Home #:_____Cell:_____Work:_____

Address:_____ Postal Code: _____

Email: _____Dentist Name:_____

Emergency Contact Name: _____Phone:_____

MEDICAL INFORMATION:

List any drugs or homeopathic medications/vitamins being taken & purpose: (ie Aspirin, CBD, Ginko, etc)

_____

_____

Do you have one of the following: **A1C #** for diabetes or **INR #** for blood thinners? _____

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

_____

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

* HIV/AIDS	Diabetes Type I or II	* Stroke	* Pregnant	*Tooth Pain	* Present Smoker
* Asthma	* High Blood Pressure	* Pace Maker	* Menopause	* Loose Teeth	* Past Smoker
* Sleep Apnea	* Low Blood Pressure	* Ulcers	* Hormone Supp.	* Food Impaction	*Vaping
* C-PAP Machine	*Rheumatic Fever	* Anemia	* General Anxiety	* Bleeding Gums	* Marijuana Use
* Lung Disease	*Shortness of Breath	* Bruise Easily	* Dental Anxiety	* Dry Mouth	* Drug Use
* Heart Murmur	* Epilepsy / Seizures	* COPD	* High Cholesterol	* Kidney Disease	* Glaucoma
* Heart Disease	* Emphysema	* Past Cancer	* Migraines	* Bad Breath	* Skin Rashes
* Artificial Joints	* Fainting / Dizziness	* Present Cancer	* Arthritis	*TMJ Pain	* Psoriasis
* Pre Medication	* Hepatitis A / B / C	* Chemo/Radiation	* Osteoperosis	* Nightguard Worn	* Liver Disease

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

The above answers are true to the best of my knowledge. If I have any medical changes I will inform the office ASAP. I understand all appointments are paid in full on the same day. I consent to intraoral photos for documentation.

Patient Name *Signature* *Date*

_____ _____ _____