MID-PENINSULA PERIODONTICS

A CENTER FOR PERIODONTAL
SPECIALTY CARE AND DENTAL IMPLANTS J. MARK BECKSTEAD, DDS, Inc.

Patient Information (Please complete both sides)

Date _____

Name (Mr. Mrs. Ms. Dr.) _____

Home address _____

City _____ State _____ Zip _____

Home/Cell phone _____

email _____

Birthdate _____ Age _____

Soc. sec. # _____

Spouse's name _____

Birthdate _____ Age _____

Social Security # _____

Responsible party if patient is a minor _____

College attending _____

EMPLOYMENT

Occupation _____

Employer name _____

Work address _____

_____

City _____ State _____ Zip _____

Work phone _____

email _____

SPOUSE'S EMPLOYMENT

Occupation _____

Employer name _____

Work address _____

City _____ State _____ Zip _____

Phone number _____

Insurance Information If you have dental insurance, please complete the following and apprise us as any changes occur in your coverage.

PRIMARY DENTAL COVERAGE

Subscriber name _____

Insurance company _____

Insurance company address _____

_____

Group or policy # _____

Subscriber ID# _____

SECONDARY DENTAL COVERAGE

Subscriber name _____

Insurance company _____

Insurance company address _____

_____

Group or policy # _____

Subscriber ID# _____

ASSIGNMENT & RELEASE

I recognize that I am financially responsible for any services rendered to me at this office. As a special service to me, insurance claims may be prepared and submitted on my behalf. I hereby authorize this office to release any information to my insurance company that is needed for the filing of my claims.

Signature _____ Date _____

Dental History

Referred by _____

Current dentist _____ How long? _____

Previous dentist _____ City _____

When was your last cleaning? _____

How many cleanings per year? _____

Have you had recent xrays? _____

Dental History (Continued from front)

DO YOU HAVE OR HAVE YOU EVER HAD (Please circle)

Head or neck injuries	Yes / No	Trouble opening or closing mouth	Yes / No	Problems of the TMJ (jaw joint)	Yes / No
Sensitive teeth	Yes / No	Prolonged bleeding after extractions	Yes / No	Dissatisfaction with the appearance of your teeth	Yes / No
Grinding or clinching teeth	Yes / No	Orthodontic treatment (braces)	Yes / No		
Difficulty chewing	Yes / No	Periodontal disease (Pyorrhea)	Yes / No		

Medical History

Primary physician _____ How long? _____ Specialty _____

Office address _____ Phone number _____

Secondary physician _____ How long? _____ Specialty _____

Office address _____ Phone number _____

DO YOU HAVE OR HAVE YOU EVER HAD (Please circle)

1. Circle any medication you have had an adverse reaction to:
   - aspirin
   - penicillin
   - erythromycin
   - tetracycline
   - codeine
   - sedatives/sleeping pills
   - dental anesthetics
   - other medications (list)
2. Hospitalization for illness or surgery Yes / No
3. Hepatitis Yes / No
4. Jaundice (yellow skin and eyes) Yes / No
5. Epilepsy Yes / No
6. Arthritis Yes / No
7. Venereal disease Yes / No
8. Rheumatic fever Yes / No
9. Scarlet Fever Yes / No
10. Anemia or other blood disorder Yes / No
11. Prolonged bleeding due to slight cut Yes / No
12. Kidney disease Yes / No
13. Diabetes Yes / No
14. Stomach or duodenal ulcer Yes / No
15. Liver disease Yes / No
16. Tuberculosis Yes / No
17. Emphysema Yes / No
18. Thyroid or parathyroid disorder Yes / No
19. Heart trouble Yes / No
20. Heart murmur Yes / No
21. Prosthetic heart valve Yes / No
22. Prosthetic joint (hip or knee) Yes / No
23. Arteriosclerosis Yes / No
24. High blood pressure Yes / No
25. Low blood pressure Yes / No
26. Persistently swollen ankles Yes / No
27. A stroke Yes / No
28. Shortness of breath on mild exertion Yes / No
29. Chest pain Yes / No
30. Hives, skin rash, hay fever Yes / No
31. Psychiatric treatment Yes / No
32. A tumor or abnormal growth Yes/ No
33. Radiation treatment by cobalt, radium, xray or any other source Yes / No
34. Glaucoma Yes / No
35. Contact lenses Yes / No
36. Prostate disorders Yes / No
37. Blood transfusions Yes / No
38. Substance abuse (alcohol, drugs IV) Yes / No
39. Immune deficiency syndrome (HIV, AIDS) Yes / No
40. Asthma Yes / No

ARE YOU

41. Presently being treated for illness Yes / No
42. Taking any medications (please list) Yes / No
43. Aware of any recent weight change Yes / No
44. Often thirsty Yes / No
45. Urinating more than six times a day Yes / No
46. Often exhausted or fatigued Yes / No
47. A smoker Yes / No
48. Generally a nervous person Yes / No
49. Often unhappy or depressed Yes / No
50. Aware of health change in the past year Yes / No

IF FEMALE, ARE YOU NOW

51. Pregnant Yes / No
52. Taking birth control pills or hormones Yes / No
53. Presently in menopause "change of life" Yes / No
54. Past menopause Yes / No

PLEASE EXPLAIN FULLY ANY "YES" ANSWERS ABOVE

_____

_____

_____

_____

_____

_____

If there are any changes in my medical condition or history I will notify the dentist or your office.

Patient Signature _____ Date _____

Reviewed by _____ Date _____

Reviewed by _____ Date _____

Reviewed by _____ Date _____