J. FRED FELTON, D.D.S.

Practice Limited to Periodontics

Name: _____ Employer: _____

Address: _____ Marital Status: _____ Spouse's Name: _____

City: _____ State: _____ Zip: _____ Spouse's Employer: _____

Home Phone: _____ Emergency Contact: _____

Business Phone: _____ Relationship: _____ Phone: _____

Cell Phone: _____ Referred By: _____

Social Security No.: _____ Dentist: _____

Birth Date: _____ Height: _____ Weight: _____ Physician: _____

MEDICAL HISTORY

Do you have or have you ever had:

Yes	No	?		Yes	No	?		Yes	No	?	
___	___	___	Heart Trouble	___	___	___	Diabetes	___	___	___	Tuberculosis
___	___	___	Congenital Heart Problems	___	___	___	Jaundice	___	___	___	Kidney Disease
___	___	___	Heart Murmur	___	___	___	Hepatitis	___	___	___	Arthritis
___	___	___	Heart Surgery	___	___	___	Cancer	___	___	___	Joint Replacement Prosthesis
___	___	___	Rheumatic Fever	___	___	___	Glaucoma	___	___	___	Stroke
___	___	___	Cardiac Pacemaker	___	___	___	Sinus Trouble	___	___	___	Epilepsy
___	___	___	Heart Valve Prosthesis	___	___	___	Persistent Cough	___	___	___	Psychiatric Care
___	___	___	High Blood Pressure	___	___	___	Asthma	___	___	___	Child Births
___	___	___	Low Blood Pressure	___	___	___	HIV/AIDS	___	___	___	Blood Transfusion
___	___	___	Stomach Ulcers	___	___	___	Sexually Transmitted Disease	___	___	___	Autoimmune Disease
___	___	___	Osteoporosis	___	___	___	Alcohol / Drug Use	___	___	___	Exessive Bleeding

1. Have you had a recent complete physical examination? _____ When? _____
2. Has there been any change in your general health in the last year? _____ Explain: _____
   _____
3. Have you been under a doctor's care, been hospitalized or seriously ill during the past two years? _____
   Explain: _____
4. Do you take any medications or drugs (prescription or over-the-counter) including aspirin, vitamins, hormones, antacids, steroids, antibiotics, birth control pills or herbal remedies presently or within the last six months? If so, please list.

   Drug / Dose & Frequency — Drug / Dose & Frequency

   _____ _____

   _____ _____

   _____ _____
5. Allergies: Are you allergic to or have you had a reaction to: (To all **yes** responses, specify type of reaction.)
   Local anesthetics _____ Aspirin _____
   Penicillin or other antibiotics _____
   Sulfa drugs _____ Codeine or other narcotics _____
   Metals _____ Latex _____
   Iodine _____ Hay Fever/Seasonal _____
   Other _____
6. Have you ever experienced excessive bleeding that required special treatment? _____ Explain: _____
7. Is there a history of diabetes in your immediate family? _____
8. Are you required to restrict your diet, work or activities in any way? _____ Explain: _____
9. Do you smoke cigarettes? _____ cigars? _____ pipe? _____ How many per day? _____ For how long? _____
10. Have you ever been treated for a growth or tumor in any part of your body? _____ Explain: _____
11. Are you under a great deal of stress on a daily basis, or has your daily stress increased? _____

12. Do you have frequent headaches? _____ Duration? _____
13. Have you been advised by a physician or dentist to premedicate with an antibiotic prior to a dental visit? _____
    If yes, what is the medication?_____
14. Do you have any disease, condition or problem not listed above that you feel we should know about? If so, please explain:
    _____

WOMEN:

Are you pregnant? _____ Due Date: _____ Is your menstrual cycle regular? _____

Have you reached menopause? _____ Are you having any menopausal symptoms? _____

DENTAL HEALTH HISTORY

Check any of the following which you may have had or experienced:

_____ Injury to Face or Jaw	_____ Sensitivity to Hot/Cold	_____ Aches in Jaw Joint
_____ Slow Healing Mouth Sores	_____ Mouth Odor	_____ Clicking/Popping in Jaw
_____ Fever Blisters	_____ Bad Taste in Mouth	_____ Jaw Locking
_____ Mouth Ulcers	_____ Tired Jaw or Sore Muscles	_____ Change in Bite
_____ Swollen Gums	_____ Grind Teeth	_____ Loose Teeth
_____ Bleeding Gums	_____ Dry Mouth	_____ Food Catches Between Teeth

Which of the following do you use on a daily basis?

_____ Toothbrush	_____ Floss	_____ Proxabrush	_____ Stimudents
_____ Toothpicks	_____ End-Tuft Brush	_____ Fluoride Rinse	_____ Mouthwash

1. If you are currently experiencing pain in your mouth, where is it located?_____
2. How did it come to your attention that you have a periodontal problem? _____
3. Do you feel strongly about keeping your teeth for the rest of your life? _____
4. Are you happy with the appearance of your teeth?_____
5. Have you had orthodontic therapy (braces)? _____ Type: _____ When? _____
6. Have you had previous periodontal (gum) treatment? _____ Type: _____ When?_____
7. Have you had oral surgery? _____ Type: _____ When? _____
8. Have you had crown and/or bridgework? _____ When?_____
9. Have you ever worn a bite guard, bite plane or night guard? _____ When?_____
10. Have you noticed any change in the position of your teeth? _____ Explain: _____
11. Do you have any difficulty in chewing? _____ Explain: _____
12. Is it difficult to open your mouth wide? _____
13. Are you worried about receiving dental treatment? _____ If so, what is your main concern? _____
14. Have you had any problems associated with previous dental treatment? _____

Present Dentist: _____ How Long?_____

Last Dental Treatment:_____ For What? _____

Last Cleaning: _____ Last X-rays:_____

Pattern of Dental Care: _____ regular _____ sporadic _____ infrequent

I understand the above information and guarantee this form was completed correctly to the best of my knowledge. I understand it is my responsibility to inform this office of any changes to the information I have provided. I will not hold the dentist, or any member of the staff responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form. I authorize the staff to perform any necessary services deemed appropriate for diagnosis and treatment. I authorize Dr. Felton to release any information required to process insurance claims. I authorize treatment and agree to pay all fees and charges for such treatment. Our policy requires payment of estimated copayment in full at time of service, unless other arrangements have been made. I acknowledge that payments will not be delayed or withheld because of any insurance coverage. I acknowledge that all proceeds of insurance are assigned to this office where applicable. For checks returned for insufficient funds, a fee of $35 will be assessed. For payments past 30 days of receipt, a fee of $10 per month will be assessed. Broken or missed appointments affect many people. If these occur without 1 business day notice (or 2 business days for surgical appts), our office reserves the right to charge a fee. For missed surgical appts, a surgical set-up fee may be charged. If my account becomes assigned to a collection agency, I agree to pay all collection agency fees, court costs and attorney fees up to 25%.

Signature of patient and/or guardian (SEAL) _____ Date: _____

Dr. Signature_____ Date: _____