

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	?
_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____
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_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____

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 | _____ Stimulents |
| _____ Toothpicks | _____ End-Tuft Brush | _____ Fluoride Rinse | _____ Mouthwash |

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