Ronald H. Watkins, D.D.S., M.S.D.

Practice Limited to Periodontics and Implants

Pharmacy_____

Welcome to Our Office

We are pleased to have you as a patient.

The information contained herein is considered confidential. Your past medical history is essential to providing quality care. Please take the time to respond accurately to each question.

PLEASE PRINT

Name			Email Address				
Address			City	State	Zip		Phone
Occupation:		Address	City	State	Zip		Phone
Employer:							
Name of Spouse		Address	City	State	Zip		Phone
Occupation:		Address	City	State	Zip		Phone
Employer:							
Birthdate	Marital Status	Sex	Height	Weight	Children	Referred By	

Social Security Number

Insurance Company

1. _____
2. _____

Policy Holder's Name

1. _____
2. _____

Family Dentist: _____ How Long: _____

Present Dental Complaints: _____

Have you ever been treated for periodontal disease? _____ Date: _____ Dr. _____

Do you think your teeth are affecting your general health in any way? _____

What are your reasons for seeking periodontal care? _____

Are you unhappy with your teeth in any way? _____

What do you consider to be the state of your general health? _____

Has there been any major change in your general health in the last year? _____

Date of last physical exam? _____

Are you under your physician's care now? Yes____ No____ Reasons: _____

_____

Physician(s)	Date of last visit	Findings
1) _____	_____	_____
2) _____	_____	_____

List all medications you are currently taking: 1) _____ 2) _____

3) _____ 4) _____ 5) _____

Do you or have you had an allergic reaction to any medications or non-medications? Please list below:

1) Non-medications: _____

2) Medications:

☐ Aspirin	☐ Tylenol	☐ Erythromycin	☐ Dental Anesthetics
☐ Percodan	☐ Codeine	☐ Tetracycline	☐ Iodine
☐ Valium	☐ Penicillin	☐ Cortisone	☐ Sulfa
☐ Demerol	☐ Barbiturates	☐ Fluoride	☐ Other: _____

Have You Had or Do You Currently Have:

Please Check	Yes	No		Yes	No		Yes	No
Rheumatic Fever	☐	☐	Contact Lenses	☐	☐	Blood Disorders	☐	☐
Heart Murmur	☐	☐	Cancers/Tumors	☐	☐	Osteoporosis/Osteopenia	☐	☐
Congenital Heart Defect	☐	☐	Radiation Treatment	☐	☐	Organ Transplant	☐	☐
Pacemaker	☐	☐	Chemotherapy	☐	☐	Hospitalized	☐	☐
Heart Trouble	☐	☐	Arthritis	☐	☐	Surgery	☐	☐
Heart Attack	☐	☐	Artificial Joints/Implants	☐	☐	Numbness/Tingling	☐	☐
Chest Pains (Angina)	☐	☐	Physical Limitations	☐	☐	Neurological Disorders	☐	☐
Arteriosclerosis	☐	☐	Thyroid Disease	☐	☐	Epilepsy (Seizures)	☐	☐
Mitral Valve Prolapse	☐	☐	Parathyroid Disease	☐	☐	Psychiatric Treatment	☐	☐
High Blood Pressure	☐	☐	Diabetes*	☐	☐	Chemical Dependency	☐	☐
Heart Surgery	☐	☐	Hives	☐	☐	Herpes	☐	☐
Stroke	☐	☐	Allergies	☐	☐	AIDS	☐	☐
Shortness of Breath	☐	☐	Drug Reactions	☐	☐	HIV+	☐	☐
Emphysema	☐	☐	Frequent Headaches	☐	☐	Venereal Disease	☐	☐
Asthma/Hay Fever	☐	☐	Sinus Trouble	☐	☐	Antibiotics before		
Lung Surgery	☐	☐	Kidney Problems	☐	☐	dental treatment?	☐	☐
Tuberculosis	☐	☐	Steroid Treatment	☐	☐	Do you consider yourself		
Valley Fever	☐	☐	Orthodontic Treatment	☐	☐	a nervous person?	☐	☐
Prostate Disorder	☐	☐	Cortisone	☐	☐	Do you smoke?	☐	☐
Ulcers	☐	☐	Anemia	☐	☐	If yes, how much? _____		
Liver Disease	☐	☐	Bruise Easily	☐	☐	* If yes Diabetes ☐ Type I ☐ Type II		
Jaundice	☐	☐	Hemophilia	☐	☐	Latest A1C _____ Date _____		
Hepatitis	☐	☐	Blood Thinners /Aspirin	☐	☐			
Glaucoma	☐	☐	Blood Transfusion	☐	☐			

For Women Only:

	Yes	No		Yes	No
1) Are you pregnant?	☐	☐	4) Are you taking birth control pills, estrogen, or other hormonal supplements?	☐	☐
2) Are your menstrual cycles regular?	☐	☐			
3) Have you reached menopause?	☐	☐	5) Are you nursing?	☐	☐

Are You Having:

	Yes	No		Yes	No		Yes	No
Difficulty Chewing	☐	☐	Bleeding Gums	☐	☐	Tooth Sensitivity: Hot, Cold, Sweets	☐	☐
Pain in Teeth or Gums	☐	☐	Loose Teeth	☐	☐	Changing Bite	☐	☐
Receding Gums	☐	☐	Bad Taste in Your Mouth	☐	☐	Numbness in Jaw	☐	☐
Grind or Clench Your Teeth?	☐	☐	Shifting Teeth	☐	☐			

If you are missing teeth, wearing dentures, or have removable artificial teeth, would you be interested in learning if you qualify for **dental implants** for permanent tooth (teeth) replacement? _____

Is there any other medical information not listed which would be important or of benefit in helping us take better care of you?

_____

I understand I am financially responsible for all services rendered regardless of my insurance coverage.

Signature: _____ Date: _____