Advanced IMPLANT & PERIO CENTER

901 Dupont Rd., Suite 101 • Louisville, KY 40207
Telephone: (502) 899-3000 • Fax: (502) 899-9919
e-Mail: mail@advancedimplantandperio.com

PATIENT ACQUAINTANCE FORM

TODAY'S DATE:______________________

PATIENT NAME:_____________________PREFERRED NAME:___________________________________

ADDRESS:___________________________CITY:_______________STATE:_________ZIP:___________

HOME.PH:______________________WK.PH:_____________________CELL:_______________________

BIRTHDATE:_____________SS#:__________________SEX (M/F)_______MARITIAL STATUS:________

NAME OF RESP. PARTY: ______________________________DOB:_______________________________

INSURED NAME: ___________________________________SS#:_________________________________

EMPLOYER:________________________ADDRESS:____

INSURANCE NAME: ____

REFERRED BY: _____________________GENERAL DENTIST: ___________________________________

PHARMACY NAME & NUMBER: ____

EMERGENCY NAME AND #:____

HEALTH HISTORY

1. Are you in good health ………………………………………………………………………...	____YES	____NO
2. Have you ever been hospitalized for any illness or operation …………………………………	____YES	____NO
3. Are you taking antibiotics, sulfa drugs, anticoagulants? ………………………………………	____YES	____NO
4. Are you taking blood pressure medicine, tranquilizers, or iodine? ……………………………	____YES	____NO
5. Are you taking codeine, narcotics, or any other drug? ……………………………………...	____YES	____NO
6. Do you wear glasses and/or contacts? ………………………………………………………	____YES	____NO
7. Do you drink alcohol? ………………………………………………………………………	____YES	____NO
8. Do you smoke or use smokeless tobacco? ………………………………………………….	____YES	____NO
9. Are you pregnant or nursing? …………………………………………………………….	____YES	____NO
10. Do you have menstrual problems, take oral contraceptives, or are you on hormone therapy?	____YES	____NO
11. Are you experiencing oral pain, headaches, earaches, or neck pain? ………………………...	____YES	____NO
12. Please list all medications, dosage of each, and reason for taking the medications:		

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DENTAL HISTORY

1. Are you satisfied with your tooth appearance and chewing capabilities? ………………..___YES___NO
2. If you could wave a magic wand across your mouth & change anything, what changes would you make?
____
3. What were some positive dental experiences that you have had that you would like repeated?____________________
____
4. What is a negative dental experience that you would like to avoid? ______________________________________
____

CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE HAD OR PRESENTLY HAVE:

Abnormal Bleeding/surgery	Emotional disturbances	Liver Disease
AIDS/HIV infected	Emphysema	Osteoporosis
Anemia	Epilepsy/seizures/fainting spells Pacemaker	Persistent cough or cold
Arthritis	Family history of blood disorders	Shortness of breath on exertion
Asthma	Gonorrhea	Sickle Cell
Blood Pressure Problems	Glaucoma	Sinus Trouble
Blood Transfusion	Heart Attack/trouble/damaged valve	Heart Murmur
Chemotherapy	Hepatitis A,B,C,D	Stomach Ulcers
Chronic Bronchitis	Hyperthyroidism	Stroke
Congenital/Rheumatic heart disease	Hemophilic	Kidney trouble
Coronary insufficiency	Syphilis	Tumors/Malignancy
Diabetes	Tuberculosis	Vomited Blood

Other:____

ARE YOU ALLERGIC TO OR HAVE YOU REACTED ADVERSELEY TO ANY OF THE FOLLOWING:

Aspirin	Codeine	Erythromycin	Penicillin	Sleeping Pills
Barbiturates	Dental anesthetics	Iodine	Sedatives	Sulfa Drugs

Other:____

PLEASE CIRCLE ANY OF THE FOLLOWING THAT WOULD KEEP YOU FROM HAVING DENTAL TREATMENT:

Fear of Pain   Missing work   Lack of concern   Other__________________________

Upon acceptance of treatment, I hereby authorize and request the performance of dental services for myself. I also give my consent to any advisable dental procedures, medications or anesthetics to be administered by Dr. Robert Schroering, Dr. Kenneth Parrish or by his supervised staff for diagnostic purposes or dental treatment. These records may include study models, photos, x-rays and blood studies. I understand and acknowledge that I am financially responsible for the services provided for myself regardless of insurance coverage. I give Dr. Robert Schroering, Dr. Kenneth Parrish permission to use any photographs or other dental records for display or for instruction with other dentists who may be in training. To the best of my knowledge, the information provided is accurate.
I consent to treatment by the dental hygienist when the supervising dentist is not on the premises.

Patient/Responsible Party's signature:____

Doctor's Signature:____