CHAPEL HILL
PERIODONTICS & IMPLANTS

PATIENT INFORMATION

Patient Name: _____ **Date:** _____
Last **First** **MI**
How do you prefer to be addressed by the doctor and staff? _____
Please circle one: Mr. Mrs. Ms. Miss. Dr. Rev. Other: _____
Address: _____ **Home phone:** _____
_____ **Work phone:** _____ **Ext.** _____
_____ **Cell phone:** _____
Date of Birth _____
SSN (if insured) _____ **Male** _____ **Female** _____
Email _____
Marital Status: Married _____ **Single** _____ **Divorced** _____ **Widowed** _____
In case of emergency please call _____ **Phone #** _____
Whom can we thank for referring you to our practice? _____

EMPLOYMENT INFORMATION

Occupation/Former Occupation: _____
Employer Name/Former Employer Name: (please no abbreviations) _____
Employer Address: _____
City: _____ **State:** _____ **Zip Code:** _____

SPOUSE OR PARENT EMPLOYMENT INFORMATION

Spouse or Parent's Name: _____
Occupation: _____
Employer Name: (please no abbreviations) _____
Employer Address: _____
City: _____ **State:** _____ **Zip Code:** _____
If spouse or parent carries the insurance, please provide the following information:
Social Security #: _____ **Date of Birth** _____

Please note that the adult accompanying a minor (under the age of 18) is financially responsible for that patient, no exceptions.

I have completed this form fully and completely and certify that I am the patient or duly authorized general agent of the patient authorized to furnish the information requested.

I understand that payment for professional services is the sole responsibility of the patient and is due as services are rendered. We do not render services on the basis that insurance companies will pay our fees, but we will be happy to assist you in filing claims for insurance reimbursement.

_____ _____ _____
Date **Signature of Patient or Parent** **Relationship to Patient**

Medical History Form

Medical Information:

Dental professionals primarily treat the area in and around your mouth. Since your mouth is part of your body any medications you are taking as well as your medical history have an important relationship with your Dental Treatment. Please answer the following questions.

Preferred Pharmacy: _____

Address: _____ **Phone #:** _____

Are you seeing a Family Physician? If so, please enter name, phone number, and date of last visit.

Physicians Name: _____

Phone Number: _____

Date of Last Visit: _____

Date of Last physical exam: _____

Have you recently (in the last two years) been hospitalized or had major surgery?

Date of Hospitalization: _____

Reason: _____

Date of Major Surgery: _____

Type of Surgery: _____

Please go over the following section and indicate which of the following you have or have had. If you need to add any further information, please enter it at the end.

Yes	No	Conditions
☐	☐	Abnormal Bleeding
☐	☐	Alzheimer's Disease/Dementia
☐	☐	Anaphylaxis
☐	☐	Anemia
☐	☐	Anxiety
☐	☐	ADHD/ADD
☐	☐	Arthritis/Gout
☐	☐	Aspirin Use
☐	☐	Asthma
☐	☐	Autoimmune Diseases
☐	☐	Artificial Heart Valve
☐	☐	Angina Pectoris
☐	☐	Blood Disorders
☐	☐	Blood Thinners
☐	☐	Blood Transfusions
☐	☐	Bruise Easily
☐	☐	Colitis
☐	☐	Cancer
☐	☐	Chemotherapy
☐	☐	Congestive Heart Failure
☐	☐	COPD
☐	☐	Depression
☐	☐	Endocarditis
☐	☐	Diabetes **Last HbA1C**:____
☐	☐	Dialysis

Yes	No	Conditions
☐	☐	Dizziness/Fainting
☐	☐	Drug Dependence/Abuse
☐	☐	Emphysema
☐	☐	Epilepsy
☐	☐	Alcohol Abuse
☐	☐	Excessive Bleeding
☐	☐	Frequent Headaches/Migraines
☐	☐	Glaucoma **Type**:_____
☐	☐	Head Injuries
☐	☐	HIV/AIDS
☐	☐	Hearing Problems
☐	☐	Heartburn
☐	☐	Heart Defects/Repair
☐	☐	Heart Attack **Date**: _____
☐	☐	Heart Murmur
☐	☐	Hemophilia **Type:**_____
☐	☐	Herpes **Type:**_____
☐	☐	Hepatitis **Type**: _____
☐	☐	High Blood Pressure
☐	☐	High Cholesterol
☐	☐	IBS
☐	☐	Joint Replacement **Date:** ____
☐	☐	Kidney Problems
☐	☐	Leukemia
☐	☐	Liver Disease

Yes	No	Conditions
☐	☐	Low Blood Pressure
☐	☐	Lupus
☐	☐	Nervous Disorders
☐	☐	Nasal Allergies/Hay Fever
☐	☐	Organ Transplant
☐	☐	Fever Blisters
☐	☐	Osteoporosis
☐	☐	Osteoarthritis
☐	☐	Psychiatric Disorders
☐	☐	Rheumatoid Disorders
☐	☐	Sinus Problems
☐	☐	Seizures
☐	☐	Sickle Cell Diseases
☐	☐	Stomach Problems
☐	☐	Stroke/TIA **Date**: _____
☐	☐	Tachycardia
☐	☐	Thyroid Problems
☐	☐	Tuberculosis
☐	☐	Tumors
☐	☐	Ulcers
☐	☐	Venereal Disease
☐	☐	Use of NSAIDS
☐	☐	Use of Steroids
☐	☐	Pacemaker

Please enter details or any further information regarding your existing or past medical conditions: _____

_____

List all drugs/medications you are currently taking (include non-prescriptions drugs and herbal supplements):

Name:	Dosage:	Frequency:	Reason:

Are you allergic to or have had a reaction to any of the following items?

Y	N		Y	N		Y	N	
☐	☐	Barbiturates, sedatives, sleeping pills	☐	☐	Acrylic	☐	☐	Dental Anesthetics
☐	☐	Aspirin	☐	☐	Penicillin	☐	☐	Tetracycline
☐	☐	Codeine	☐	☐	Sulfa	☐	☐	Food
☐	☐	Latex	☐	☐	Clindamycin	☐	☐	Other
☐	☐	Metals	☐	☐	Erythromycin			

Have you ever taken or currently taking any bone stengthening drugs for treatment or prevention of osteoporosis?

☐ YES ☐ NO If yes, what is the name of the medication? _____ Administration route: ☐ Oral ☐ I.V.
How long have you/did you take it? _____

If you have ever been advised against taking any type of medication, please list them: _____

Have you been told by your physician that you need to take premedication(antibiotics) one hour prior to dental appointment?
☐ YES ☐ NO If yes, Name of antibiotic?_____ Dosage_____Amount_____Reason_____

If female, please answer the following:

- Are you taking birth control? ☐ YES ☐ NO
- Are you pregnant ☐ YES ☐ NO If yes, # of weeks: _____
- Are you nursing**?** ☐ YES ☐ NO

Do you smoke: ☐YES ☐NO
How many cigarettes per day:_____# of years:_____
Do you use smokeless tobacco: ☐YES ☐ NO
How may times per day:_____# of years:_____
Are you wearing a nicotine patch? ☐YES ☐ NO
If you quit smoking, how long ago?_____

Do you drink alcoholic beverages: ☐ YES ☐ NO How many drinks per day:_____Number of years:_____

Do you use any illicit drugs?: ☐ YES ☐ NO

Do you suffer from Sleep Apnea?: ☐ YES ☐ NO **Do you use a C-PAP machine?** ☐ YES ☐ NO

Are you vegan?: ☐ YES ☐ NO

- If yes, are there any materials you would prefer we do not use during your surgeries? (i.e. Animal products from bovine products)?_____

Due to religious or personal reasons, are there any materials you would prefer we do not use during your surgeries?(i.e. Animal products from bovine or porcine origins) ☐ YES ☐ NO
If yes, please specify what materials you would like us not to use:_____

How anxious are you about dental or periodontal treatment? (0 having no anxiety at all, 10 having extreme anxiety)

0 1 2 3 4 5 6 7 8 9 10

Are you interested in some form of sedation other than being numb?: ☐ YES ☐ NO

****** Are you able to lay flat in a dental chair?: YES☐ NO☐ ******

What is your major dental or periodontal concern? _____

Signature: _____ Date: _____
(If under 18, Parent or Guardian Signature required)

Office Use Only

Received by:_____ Reviewed by: _____

PERMISSION TO SHARE INFORMATION

I _____, GIVE PERMISSION TO SHARE ANY INFORMATION IN DR. GODSEY'S POSSESSION CONCERNING ME INCLUDING DENTAL AND FINANCIAL INFORMATION WITH THE FOLLOWING PERSON/PERSONS:

1. **NAME _____**
   RELATIONSHIP TO PATIENT _____ CONTACT NUMBER_____

2. **NAME _____**
   RELATIONSHIP TO PATIENT _____
   CONTACT NUMBER _____

3. **YOU MAY LEAVE MESSAGES FOR ME AT THE FOLLOWING NUMBERS:**

HOME: _____
OFFICE: _____
CELL: _____

_____ _____

PATIENT'S SIGNATURE **DATE**