Curtis Wade, dds* PS
Practice Limited to Periodontics & Implants
** Diplomate of the American Board of Periodontology*

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INFORMATION AND HEALTH HISTORY

Today's date: _____

Name: _____ Date of Birth _____
First Middle Last

Mailing Address: Street: _____

City _____ State _____ Zip _____

Home Phone #: _____ Cell Phone # _____ Work # _____

Residence address if not the same _____

Employer: _____ Occupation _____

Spouses Full Name: _____ Date of Birth _____

Employer: _____ Occupation _____

* * * * * * * * * * * *

Insurance Info: Primary Dental Ins _____ Secondary Dental Ins: _____

Subscriber _____ Subscriber: _____

SS# or ID # _____ SS# or ID# _____

Date of Birth _____ Date of Birth _____

Group # _____ Group # _____

* * * * * * * * * * * *

Referred by : _____ General Dentist _____ How long?_____

Physicians name:_____ Previous Dentist _____ How long?_____

* * * * * * * * * * * *

Name, address & phone # of close friend or relative: _____

_____

1. Do you presently have any dental problems? Explain _____

_____

2. Do your gums bleed? Yes _____ No _____

3. Have you experienced prolonged bleeding or slow healing after any tooth extraction? Yes _____ No _____

4. What would the loss of your natural teeth mean to you? _____

5. Are you under the care of a physician at present? Yes _____ No _____ Year of last exam _____

6. Please describe any current medical treatment, impending surgery, or other treatment that may affect your dental health.

_____

7. Have you ever had any serious illness? Yes _____ No _____ Explain _____

8. Do you smoke? Yes _____ No _____

9. Have you ever had a blood transfusion? Yes _____ No _____ If so, when? _____

10. Please circle any of the following, which you have had in the past or present:

a. Heart trouble	j. Lung problems	s. Kidney disease	aa. Herpes
b. Heart murmur	k. Emphysema	t. Stroke	bb. Artificial joints
c. High/Low BP	l. Tuberculosis	u. Epilepsy/ seizure	
d. Chest Pains	m. Asthma/Hay Fever	v. Arthritis	
e. Rheumatic fever	n. HIV / AIDS	w. Fainting spells	
f. Jaundice/liver	o. Sinus trouble	x. Anemia/ blood disorder	
g. Hepatitis A, B, C	p. Diabetes _____	y. Psychiatric care	
h. Cancer _____	q. Glaucoma	z. Osteoporosis	
i. Radiation treatment	r. Ulcer		

11. Have you been hospitalized in the last 5 years? _____

12. List any medicines you take regularly, either over the counter or prescription. If you have a list, please have available to copy. _____

13. Have you ever had any unusual reaction to any medication, latex, or metals? Yes _____ No _____
If so, please specify _____

14. Do you wear contacts? Yes _____ No _____

15. Women: Are you pregnant? Yes _____ No _____
Taking birth control? Yes _____ No _____
Taking hormones? Yes _____ No _____

16. Is there anything regarding your medical history that you wish to discuss with the doctor in private?
Yes _____ No _____

Patient Signature _____ Date: _____

Reviewed by: _____ Date:_____