Danny Adkins, D.D.S.

Practice Limited To Periodontics and Implant Surgery

Patient Information Form (Strictly Confidential)

Name (First) _____ (Middle) _____ (Last) _____

Email Address _____ Age_____ Birthdate_____

Address _____ Home Phone_____

City _____ State _____ Zip_____ Cell Phone _____

Social Security # _____ ❑ Male ❑ Female ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Employer _____ Occupation _____

Business Address _____ Business Phone _____

Person Responsible For This Account_____

Address_____ Home Phone_____

Business Address_____ Business Phone_____

Has Any Member Of Your Immediate Family Been A Patient Here? Yes_____ No_____ If Yes,

Whom? _____

Dental Insurance: Yes_____ No_____ Name Of Carrier_____

Employee/Subscriber Name _____ Date of Birth _____

Employer Of Insured _____

Social Security No. Of Insured _____ Plan/Group Number_____

Secondary Insurance_____

Name Of General Dentist _____ How Long His/Her Patient? _____

Address _____ Phone_____

Name Of Medical Doctor _____ Address _____

Whom May We Thank For Referring You To This Office? _____

Why Are You Now Seeking Periodontal Treatment? _____

MEDICAL HISTORY

Height_____ Weight_____ Are You In Good Health? _____

Date Of Last Physical Examination _____ Are You Being Treated By A Physician Now?_____ If Yes,

For What? _____

PLEASE CIRCLE THE CORRECT RESPONSE:

1. Have you ever had an injury to your face or jaws? ..... YES NO
2. Have you ever been treated for a growth or tumor in any part of your body? ..... YES NO
3. Have you been taking any medicines or drugs within the past year, including any you may be taking now? ..... YES NO
   If yes, please list: _____
4. **Do you take blood thinners (e. g. Plavix, Coumadin, Aspirin, Mobic, etc.)?** ..... YES NO
   If yes, what do you take? _____
5. Has there been any change in your general health in the past year? ..... YES NO
6. **Have you ever taken fenfluramine/dexfenfluramine (phen-fen or redux) appetite suppressant drugs?** ..... YES NO
   If yes, how long? _____
   If yes, had echocardiogram? ..... YES NO
7. Have you lost or gained an excessive amount of weight in recent months? ..... YES NO
8. Have you ever been seriously ill, hospitalized, or had surgery? ..... YES NO
9. **Have you ever been treated for cancer?** ..... YES NO
10. **Have you ever orally or intravenously taken a bisphosphonate drug** (Circle which one(s)) **(e. g. Fosomax, Actonel, Boniva, Didronel, Aredia, Zometa, Bonefos or Skelide)?** ..... YES NO
11. Do you bleed for a long time when you cut yourself? ..... YES NO
12. **Does your physician recommend you be premedicated (take antibiotics) prior to dental appointments due to a pre-existing medical condition such as a heart murmur, mitral valve prolapse, bone or joint replacement, etc.?** ..... YES NO
    If yes, what antibiotic? _____