Tar Heel Periodontics
AND IMPLANT DENTISTRY
The Premier Periodontal Practice of The Triangle

PROUD PARTNERS

We are happy to have you join our great family of patients and friends. The benefits of a healthy, beautiful smile are never-ending, and our goal is to provide a safe and comfortable environment while providing you the highest quality of care.

Please complete this form to the best of your ability so we can provide the best possible care.

Dental Health History Form

PATIENT NAME:_____ DATE: _____
LAST FIRST (PREFERRED NAME)

BIRTHDATE: _____ AGE: _____ SOCIAL SECURITY # : _____

MALE: _____ FEMALE: _____ SINGLE: _____ MARRIED: _____ WIDOW: _____

ADDRESS: _____
STREET APARTMENT #

_____
CITY STATE ZIP CODE

TELEPHONE (HOME) : _____ (WORK): _____ (CELL) : _____

EMAIL : _____

HEALTH INFORMATION

1. Do You premedicate before a dental visit? ☐ Yes ☐ No

   If yes, for what reason: _____

   What do you premedicate with? _____

2. Do you take blood thinners such as (Please circle):

   - Clopidogrel (Plavix)
   - Dipyridamole (Persantine)
   - Prasugrel (Effient)
   - Ticagrelor (Brilinta)
   - Vorapaxar (Zontivity)
   - Warfarin
   - Aspirin

3. Are you allergic to any medications? ☐ Yes ☐ No

   If yes, please list: _____

4. Are you currently taking any medications? ☐ Yes ☐ No

   If yes, please list: _____

5. Are you currently under the care of a physician? ☐ Yes ☐ No

   If yes, please explain: _____

6. Have you ever had any type of joint replacement? ☐ Yes ☐ No

   If yes, please explain: _____

7. Do you have or have you ever had Hepatitis A, B or C? ☐ Yes ☐ No

8. Have you ever been told you could not donate blood? ☐ Yes ☐ No

   If yes, please explain: _____

9. Have you ever had a blood test for AIDS? ☐ Yes ☐ No

   Results were: ☐ Positive ☐ Negative

10. Do you use any tobacco products? ☐ Yes ☐ No

    If yes, please explain: _____

11. Have you ever had any complications from dental treatment? ☐ Yes ☐ No

    If yes, please explain: _____

12. FEMALE PATIENTS: Are you pregnant? ☐ Yes ☐ No

    If yes, expected due date is : _____

13. Circle Yes or No to the following:

AIDS	Y	N	High Blood Pressure	Y	N
Diabetes	Y	N	Hepatitis A, B or C	Y	N
Epilepsy	Y	N	Arthritis	Y	N
Rheumatic Fever	Y	N	Prolonged Bleeding	Y	N
Heart Disease	Y	N	Cancer	Y	N
Mitral Valve Prolapse	Y	N	Asthma	Y	N
Heart Attack	Y	N	Fainting Spells	Y	N
Liver or Kidney Disease	Y	N	Tuberculosis	Y	N
Heart Murmur	Y	N	Anemia	Y	N
Stroke	Y	N	Stomach Ulcers	Y	N
Organ Transplant	Y	N	Thyroid Problems	Y	N
Chest Pain/Angina	Y	N	Latex Allergy/Reaction	Y	N
Sleep Apnea	Y	N			

Reason for this Visit : _____ Date of last dental visit: _____

To the best of my knowledge, all the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail. My signature authorizes treatment.

_____ Date : _____

Signature of patient, parent or guardian

REFERRAL INFORMATION

Whom may we thank for referring you to our practice? ☐ Another patient, friend or relative

☐ Dental Office ☐ School ☐ Social Media ☐ Other _____

Name of the person or office referring you to our practice: _____

Who is your general dentist? _____

How long have you been a patient with your general dentist? _____

DENTAL INSURANCE INFORMATION

Primary

Name of insured: _____ is the insured a patient? ☐ Yes ☐ No

Insured's Birth Date: _____

Subscriber's Social Sec. # : _____

Subscriber ID #: _____

Subscriber Group #: _____

Subscriber Address: _____
Street City State Zip Code

Subscriber's Employer Name: _____

Address: _____
Street City State Zip Code

Patients relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

DENTAL INS. CO. : _____
Full Name of Dental Insurance Carrier

DENTAL INSURANCE: ADDRESS: _____
MAILING ADDRESS Street Suite #

_____
City State Zip Code

DENTAL CLAIMS PHONE #: _____

DENTAL CLAIMS FAX # : _____ (IF AVAILABLE)

Your Health. Your Life. Our Passion.

RALEIGH/WAKE COUNTY DENTAL SOCIETY

SPEAR STUDY CLUB