HILTON ISRAELSON, D.D.S. P.A.

Diplomate, American Board of Periodontology
Periodontics, Oral Medicine and Dental Implants

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WELCOME TO OUR OFFICE **Today's Date:**_____

Name:
Mr. Mrs. Ms. Dr._____ **Preferred name:**_____

Home Address:_____ **City**_____ **State**_____ **Zip**_____

Date of Birth: Month____ **Day**____ **Year**_____ **Social Security Number**_____ **Marital Status**_____

Home phone #_____ **Mobile phone #**_____ **Work #**_____
Other #_____ **Your email address**_____

Name and address of your general dentist:_____
Phone:_____

Name and address of your physician:_____
Phone:_____

Who should be contacted in case of emergency? Name:_____
Phone#:_____

Who referred you to our office?_____
Primary reason for your visit today:_____

Date of last physical examination:_____ **Are you currently being treated by a physician?**_____
If so, what is the condition being treated?_____

Do you have, or have you ever had:

Allergies (seasonal)	___Yes	___No	Anemia	___Yes	___No
Arthritis, Osteo or Rheumatoid(circle)	___Yes	___No	Asthma/Hay Fever	___Yes	___No
Blood Disease/Transfusions (circle)	___Yes	___No	Cancer_____	___Yes	___No
Chemotherapy/Radiation (circle)	___Yes	___No	Chest Pains	___Yes	___No
Contact Lenses	___Yes	___No	Convulsions/Seizures	___Yes	___No
Diabetes	___Yes	___No	Dizziness	___Yes	___No
Epilepsy	___Yes	___No	Excessive Bleeding	___Yes	___No
Glaucoma	___Yes	___No	Heart Trouble/Disease	___Yes	___No
Heart Murmur/Valve (circle one)	___Yes	___No	Hepatitis _____	___Yes	___No
High or Low Blood Pressure (circle)	___Yes	___No	HIV Virus	___Yes	___No
Kidney/Bladder Disease (circle)	___Yes	___No	Liver Disease	___Yes	___No
Neurologic Disorders	___Yes	___No	Pacemaker	___Yes	___No
Psychiatric Treatment	___Yes	___No	Respiratory Problems	___Yes	___No
Rheumatic Fever	___Yes	___No	Shortness of Breath	___Yes	___No
Sinus Problems	___Yes	___No	Stroke	___Yes	___No
Swollen Ankles	___Yes	___No	Thyroid Trouble	___Yes	___No
Tuberculosis/Emphysema (circle)	___Yes	___No	Ulcers	___Yes	___No
Venereal Disease	___Yes	___No			

Any Prosthetic Device ___**Yes** ___ **No** **If yes, what type?** ___**Hip** ___ **Knee** ___**Other**_____

Do you have to take antibiotics before dental treatment for any reason? ___Yes ___No If yes, what do you take?_____

Allergic Reaction to any drug?	**___Yes**	**___No**			
Anesthetics	___Yes	___No	Demerol	___Yes	___No
Antibiotics _____	___Yes	___No	Dental Anesthetic	___Yes	___No
Aspirin	___Yes	___No	Sulfa	___Yes	___No
Barbiturates	___Yes	___No	Valium	___Yes	___No
Codeine	___Yes	___No			
Other	___Yes	___No	If yes, what?_____		
Any history of serious illness?	___Yes	___No	If yes, what?_____		

List any medications you currently take:_____

Please check yes or no:

Often Thirsty	___Yes	___No	Subject to frequent urination	___Yes	___No
Easily exhausted or fatigued	___Yes	___No	Subject to frequent headaches	___Yes	___No
Slow in healing	___Yes	___No	A mouth breather	___Yes	___No
Often unhappy or depressed	___Yes	___No	Sore or popping joints	___Yes	___No
Prolonged bleeding	___Yes	___No	Clench your teeth day or night	___Yes	___No
Previous gum disease/trouble	___Yes	___No	Previous orthodontic treatment	___Yes	___No
Previous gum surgery	___Yes	___No	Sore or bleeding gums	___Yes	___No
Awaken with sore jaws	___Yes	___No	Fever Blisters/Cankre sores	___Yes	___No
Do you bruise easily	___Yes	___No	Do you use tobacco products	___Yes	___No
Drink Coffee	___Yes	___No	Take Anticoagulants/Blood thinner	___Yes	___No

Are your teeth sensitive to:

Heat, Cold or Sweets (circle)	___Yes	___No	**Do you fear the dentist?**	___Yes	___No

If Female are you:

Pregnant	___Yes	___No	Nursing	___Yes	___No
Taking birth control pills	___Yes	___No	Taking hormones	___Yes	___No
Through Menopause	___Yes	___No			

Do you have any condition, disease or problem not listed above that you need to bring to our attention?
___Yes ___ No If yes, please explain:)_____

(initial):_____**I understand that the information given above is correct and to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.**

(initial):_____**I understand that I am responsible for payment due at the time of services and that any insurance coverage is between my insurance company and me.**

Signature of Patient:_____
Date:_____

Signature of Guardian:_____
Date:_____

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