Bryan J. Roy, D.D.S., M.S.D., P.C.
Practice Limited to Periodontics

CONFIDENTIAL PATIENT HISTORY

PLEASE USE BLACK OR BLUE INK ONLY

Legal Name_____ SSN_____-_____-_____ Sex M F Birth Date _____

Address_____ City_____ State_____ Zip_____

Home Phone_____ Cell Phone _____

Employer_____ Business Phone_____

Name of Spouse _____ Spouse Cell Phone_____

In case of emergency, name of relative/friend **not living with you** _____

Address_____ Phone #_____

Patient's Dentist_____ Referred By _____

Patients Physician_____ Physician Phone #_____

Cardiologist Name_____ Cardiologist Phone # _____

DENTAL INSURANCE

	Primary Dental Carrier	Secondary Dental Carrier
Employer:	_____	_____
Ins. Co.:	_____	_____
Employee:	_____	_____
Date of Birth:	_____	_____
ID #:	_____	_____

Present Health? Good_____ Fair_____ Poor_____

Circle any of the following which you <u>have had</u> or <u>have</u> at present:

Heart Condition	Lung Disease	Diabetes	Venereal Disease
Heart Attack or Stroke	Tuberculosis (TB)	Liver Disease	Genital Herpes
Heart Surgery	Asthma or Hay Fever	Kidney Trouble/Disease	AIDS/HIV positive
Heart Pacemaker	Skin Rashes or Hives	Hepatitis A(infectious)	HPV
Chest Pains (angina)	Thyroid Disease	Hepatitis B (serum)	Latex Sensitivity
Artificial Heart Valve	Epilepsy or Seizures	Blood Transfusion	Psychiatric treatment
Transplant	Glaucoma	Anemia or Hemophilia	Frequent Headaches
Rheumatic Fever	Cortisone Medicine	Cancer or Tumor	Alcoholism
High Blood Pressure	Arthritis or Rheumatism	Chemotherapy	Drug Addiction
	Fainting or Dizzy Spells	Radiation Therapy	Cold Sores

Artificial Joint _____ Date of Surgery _____

Please Circle

Do you have ***any diseases***, conditions or problems not listed on reverse side? No Yes
If yes, please explain _____

Are you presently taking any medicine or drugs (***prescription and over-the-counter***)? No Yes
If yes, list drug, dosage, and frequency_____
_____

Are you ***allergic*** to any drugs, or other substance**?** No Yes
If yes, please list _____

Are you now, or have you been under the ***care of a medical doctor***
during the last two years? No Yes
Have you ever been hospitalized or had surgery? No Yes
If yes, please explain _____

Have you ever had a reaction to a dental anesthetic? No Yes
Have you ever had complications or illness following dental treatment? No Yes
Have you ever had prolonged or unusual bleeding? No Yes
Have you ever had an injury or trauma to your face or jaw ? No Yes

Do you smoke or use smokeless tobacco? No Yes How many/much per day? _____ Yrs. of Habit? ___

Are you nervous or concerned about having dental treatments? No Yes

Women:
Are you pregnant? Due Date_____ No Yes
Are you taking birth control pills? No Yes
Do you anticipate becoming pregnant? No Yes
Have you had any complications or problems with previous pregnancy? No Yes

What do you perceive to be your main dental problem _____
_____
Describe any dental pain you have now_____
Would you be disturbed if you had to lose your teeth and wear false teeth? No Yes

Circle any of the following you have now:

Dry Mouth	Bleeding From Gums	Discharge From Gums
Food Packing Between Teeth	Loose Teeth	Bad Odor In Mouth
Burning Tongue	Puffy Or Sore Gums	Bad Taste In Mouth
Pain In Jaw Joints	Jaw Clicking	Teeth Sensitive Cold / Sweets
Clenching / Grinding Habit		

Date of last cleaning _____
Have I treated any of your family or friends?_____ Who _____
Have you had previous periodontal treatment? _____When_____
By whom_____

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform the dentist and dental staff at the next appointment without fail. I agree to pay for all services rendered (including those services not covered by my dental insurance) and, if necessary, any collection agency fees, attorney fees or cancellation charges. ***Dr. Roy has no agreement or relationship with any insurance company with the exception of Delta Dental Premier.****. I have also received the patient information sheet.*

_____ _____
Patient/Parent Signature Date