John R. Lee, D.M.D., M.S.
Practice Limited to Periodontics and Implants

WELCOME

So that we may provide you with the best possible care please complete **both sides** of this medical history form.
All information is completely confidential.

Name_____ Birthdate____/_____/_____ SS#_____

Address_____City_____State_____Zip_____

Phone_____Work_____Cell_____

Email_____Preferred Method of Contact_____

Marital Status: S M W D Male ____ Female ____ Number of Children _____

Employer_____Occupation_____

Responsible Party For Patient's Account_____SS#_____

Address_____Phone #_____

Spouse's Name (Parent or Guardian)_____

Employer_____Phone #_____ SS#_____

Whom May We Thank For Referring You?_____

Family Dentist_____How Long_____

Reason For Visit_____

Family Physician_____Phone #_____Last Visit_____

DENTAL INSURANCE INFORMATION

Primary Dental Insurance
Insured's Name_____
Insurance Co. Name_____
Address_____
_____Phone # (___)_____
Group/Plan #_____
Relation: Self____Spouse_____Child_____
Insured's Birthday _____/ _____/_____
Insured's SS#_____

Secondary Dental Insurance
Insured's Name_____
Insurance Co. Name_____
Address_____
_____Phone # (___)_____
Group/Plan#_____
Relation: Self_____Spouse_____Child_____
Insured's Birthday _____/_____/_____
Insured's SS# _____

I acknowledge that I have read/received a copy of the office's Notice of Privacy Practices.

I understand that the information that I have given is correct to the best of my knowledge. I also understand that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and/or treatment with my informed consent.

I understand that, where appropriate, credit bureau reports may be obtained.

Signature _____ Date_____

3501 N. Scottsdale Road, Suite 244 Scottsdale, AZ 85251 480-947-2031 Fax 480-941-4473
3326 N. 3rd Avenue, Suite 1 Phoenix, AZ 85013 602-277-0308 Fax 602-279-4883

www.JohnRLeePerio.com

MEDICAL HISTORY

1. How is your overall general health? Good Fair Poor Height_____ Weight _____
2. Are you being treated by a physician? If yes, explain: _____ Y N
3. Have you been hospitalized or had a serious illness in last three years? _____ Y N
4. Have you taken cortisone or steroids within the last year? _____ Y N
5. Have you had a hip/knee/joint replacement? _____ Y N
6. Do you get up often at night to urinate? _____ Y N
7. Are you thirsty much of the time? _____ Y N
8. Has anyone in your family had diabetes? Who? _____ Y N
9. Do you smoke? How much?_____ Y N
10. Are you taking?

Apirin-Daily_____	Y N	Multivitamin _____	Y N
Ephedra/Phen-fen _____	Y N	Recreational drugs_____	Y N
Vitamin E _____	Y N		
Minerals/Herbs (please list) _____			Y N

11. Please list any prescription medications you are currently taking._____
_____
12. Do you Pre-medicate with antibiotics prior to dental visits? Which one? _____ Y N
13. Have you ever experienced an allergic reaction to any of the following?

Asprin_____	Y N	Sleeping pills_____	Y N
Penicillin_____	Y N	Dental Anesthetics_____	Y N
Other Antibiotics_____	Y N	Latex_____	Y N
Codeine_____	Y N	Other drugs_____	Y N

14. Have you ever had or do you currently have:

Mitral Valve Prolapse_____	Y N	Hepatitis_____	Y N
Heart Attack_____	Y N	Diabetes_____	Y N
Heart Murmur_____	Y N	Anemia_____	Y N
Stroke_____	Y N	Thyroid trouble_____	Y N
High blood pressure_____	Y N	Tuberculosis_____	Y N
Rheumatic fever_____	Y N	Venereal Disease_____	Y N
Cancer_____	Y N	Kidney Disease_____	Y N
X-ray treatment (other than routine)___	Y N	Ulcers_____	Y N
Arthritis_____	Y N	Asthma_____	Y N
Epilepsy_____	Y N	Lung Disease_____	Y N
Bleeding problems_____	Y N	Difficulty breathing_____	Y N
Gastrointestinal disorder_____	Y N	Blood transfusion_____	Y N
Sinus problems_____	Y N	A.I.D.S._____	Y N
Alcohol/Drug abuse_____	Y N	H.I.V. positive_____	Y N

For Women Only:

1. Are you taking birth control pills?_____ Y N
2. Are you pregnant? If yes, what month?_____Y N Breast feeding?_____ Y N

DENTAL HISTORY

1. Do your gums bleed? When?_____ Y N
2. Have you ever had a gum boil? _____ Y N
3. Are your gums swollen/sore?_____ Y N
4. Are any of your teeth loose?_____ Y N
5. Are you in pain?_____ Y N
6. Are your teeth sensitive?_____ Y N
7. Have you had orthodontic treatment? When? _____ Y N
8. Have you had periodontal treatment? When? _____ Y N

Emergency Information: Name_____ Relationship_____
Address _____ Phone # _____

MEDICAL HISTORY UPDATE

Signature_____Date_____

Signature _____Date_____