Leslie Ann Carroll, DMD, MS, PC
1428 W. Hebron Pkwy
Ste 140
Carrollton TX 75010
(972)394-1234
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topgums@ntperio.com

Patient Name: ______ ______ ______ ______
Last First MI Preferred Name

Date of Birth ____________________ Social Security Number: ____________________

Address: ______ ______
______ ______ ______
City State Zip Code

Phone: ______ ______ ______ ______ Best time to call: ______
Home Work Ext Mobile

Driver's License: ____________________ Email: ________________________________

Emergency Contact (Name, Telephone #, Relationship to Patient):

General Dentist:

REGULAR MEDICATIONS / ALLERGIES:

Please list any drug ALLERGIES or sensitivities:

Do you smoke? _________ If you are a Smoker, how many cigarettes do you smoke daily?

Please list any drugs or medications you are currently taking:

Primary Care Physician (Name & Phone Number):

What was the date of your last complete physical?

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Please list your height & weight:

MEDICAL CONDITIONS (Check all that apply)

- [ ] AIDS
- [ ] Allergies: Drug
- [ ] Allergies: Seasonal
- [ ] Anemia
- [ ] Angina Pectoris
- [ ] Arteriosclerosis
- [ ] Arthritis
- [ ] Artificial Heart Val
- [ ] Artificial Joint
- [ ] Asthma
- [ ] Blood Disorders
- [ ] Blood Tranfusion
- [ ] Breathing Disorders
- [ ] Bruises easily
- [ ] Cancer Or History of
- [ ] Cancer
- [ ] Chemotherapy
- [ ] Chronic Cough
- [ ] Codeine Allergy
- [ ] Cold Sores
- [ ] Cong. Heart Disease
- [ ] Cortisone Medication
- [ ] Cosmetic Surgery
- [ ] Diabetes
- [ ] Drug Addiction
- [ ] Epilepsy/Seizures
- [ ] Fainting/Dizzy spell
- [ ] Family Hist.Diabetes
- [ ] Frequent Headaches
- [ ] Glaucoma
- [ ] Hay Fever
- [ ] Heart Disease/Attack
- [ ] Heart Failure
- [ ] Heart Murmur
- [ ] Heart Pacemaker
- [ ] Heart Transplant
- [ ] Hemophilia
- [ ] Hepatitis
- [ ] Hiatal Hernia
- [ ] High Blood Pressure
- [ ] History of Surgery
- [ ] HIV
- [ ] Kidney trouble
- [ ] Latex Allergy
- [ ] Liver Disease
- [ ] Mitral Valve Prolap
- [ ] Nervousness
- [ ] Pain in Jaw Joints
- [ ] Penicillin Allergy
- [ ] PRE-MED
- [ ] Psychiatric Trt
- [ ] Radiation Therapy
- [ ] Sickle Cell Disease
- [ ] Sinus Trouble
- [ ] Sleep Apnea
- [ ] Smoker
- [ ] Special Diet
- [ ] Stroke
- [ ] Sulfa Drug Allergy
- [ ] Thyroid Problems
- [ ] Tuberculosis
- [ ] Ulcers
- [ ] Yellow Jaundice

Please list any other medical conditions:____

Have you ever had any problems/complications with General Anesthesia or IV Sedation?

- [ ] None
- [ ] Nausea
- [ ] Allergy
- [ ] Other

If you have a History of Surgery, please list all major surgeries and the year they were done below.

If you have Artificial Joint(s), which joint(s) have you had replaced?

If you have diabetes, or a history of diabetes, which of the following types have you had? What was your last A1C? Date of last A1C? ________________

If you have a History of Cancer, which type of cancer have you had?

Have you, or are you currently, having any radiation treatment? (If so, when and where):

Do you take any of the following BLOOD THINNERS / ANTICOAGULANTS?

☐ Coumadin/Warfarin ☐ Aspirin (81mg) ☐ Aspirin (325 mg) ☐ Plavix

Name & Phone # of Prescribing Physician (for Blood Thinners/Anticoagulants):

What was your most recent INR? ____

If you Pre-Medicate prior to your dental visits, list the antibiotic you have been prescribed and instructions:

Have you ever taken Bisphosphonates? (Example - Fosamax or Alendronate)

○ Yes ○ No

DENTAL CONDITION:

How often do you see your General Dentist for Dental Hygiene Maintenance? When was your last dental hygiene visit?

Have you ever been told you have gum trouble or been treated for periodontal disease? If so, please list when you had it and what you had done.

Have you ever had Orthodontic treatment? If so, when you had this treatment and who was your orthodontist?

Do you ever clench your teeth? If so, under what circumstances?

Do you ever have swollen gums? ________ Bleeding gums? __________ Teeth sensitivity? ______________

Are you unhappy with the appearance of your teeth or smile?

◯ Yes ◯ No

Would you be disturbed if you lost your teeth?

◯ Yes ◯ No

FOR WOMEN ONLY:

Are you pregnant? If YES, what week of your pregnancy are you in? _______ Are you currently nursing? __________
Are you currently taking birth control pills? ____________

The undersigned hereby authorizes the doctor or staff to take x-rays, study models, photography, or any diagnostic aids deemed appropriate to make a thorough diagnosis. All responsibility of payment for Dental Services provided in this office for myself or my dependent is totally mine, due and payable at the time of service unless a previous financial arrangement has been made.

☐ By checking this box, I certify that all the above questions were answered truthfully and to the best of my knowledge with the understanding that they were necessary to provide quality care in a safe and efficient manner.

Signature: ______________________ Date:

Physician Signature

Signature: ______________________ Date:

Response Date: