Broadway Perio

DR. D. ROEMERMANN INC.
Board Certified Specialist in Periodontics

PATIENT INFORMATION

Name (Miss, Mrs., Ms, Mr., Dr.) _____ Date of Birth _____
SURNAME GIVEN NAMES

Address Street _____ Email _____

City _____ Postal Code _____ Phone _____

Employer _____ Occupation _____

Business Address _____ Phone _____

Name of Spouse/Partner _____

Family Dentist _____ Phone _____

Family Physician _____ Phone _____

Referred By _____ Phone _____

Whom should we contact in the event of an emergency? _____ Phone _____

Do you have dental insurance: ☐ Yes ☐ No

Name of Insurance Company _____ Group / Policy Number _____

I.D. # of Subscriber _____ Div / Acct _____ Dependent _____

Name of Subscriber _____ Subscriber's Date of Birth _____

Do you have two insurance plans? ☐ Yes ☐ No If yes, please give details:

Name of Insurance Company _____ Group / Policy Number _____

Name of Subscriber _____ Subscriber's Date of Birth _____

Name of Employer _____

I.D. # of Subscriber _____ Div / Acct _____ Dependent _____

MEDICAL HISTORY

The following information is required to thoroughly diagnose any condition, and to give the highest possible standard of professional services. All information will be kept strictly confidential.

1. ☐ Yes ☐ No Are you now under the care of a physician? (a) If so, what is the condition being treated?

_____

2. ☐ Yes ☐ No Have you had any serious illness or operation? (a) If so, what was the illness or operation?

_____

3. ☐ Yes ☐ No Have you ever been hospitalized? (a) If so, what was the problem?

_____

4. ☐ Yes ☐ No Are you taking any drug or medicine? (a) If so, what? _____

_____

5. ☐ Yes ☐ No Are you allergic or have you reacted adversely to any drug or medicine: e.g. local anaesthetic (freezing); Penicillin or other antibiotics; barbiturates, sedatives, analgesics (pain killers)

_____

6. **Do you/or have you had any of the following diseases or problems?**

☐ Yes	☐ No	(a)	Rheumatic fever or rheumatic heart disease?
☐ Yes	☐ No	(b)	Congenital heart disease?
☐ Yes	☐ No	(c)	High blood pressure, cardiovascular disease: e.g. heart trouble, heart attack, arteriosclerosis (hardening of the arteries); stroke?
☐ Yes	☐ No	(d)	Chest pains or shortness of breath?
☐ Yes	☐ No	(e)	Asthma, hay fever, skin rash? History of sinus infections?
☐ Yes	☐ No	(f)	Fainting spells or seizures: e.g. epilepsy?
☐ Yes	☐ No	(g)	Diabetes?
☐ Yes	☐ No	(h)	Kidney disease?
☐ Yes	☐ No	(i)	Liver disease or jaundice?
☐ Yes	☐ No	(j)	Endocrine disorder: e.g. thyroid disease?
☐ Yes	☐ No	(k)	Lung or breathing disorders: e.g. tuberculosis?
☐ Yes	☐ No	(l)	Gastrointestinal disease: e.g. ulcers?
☐ Yes	☐ No	(m)	Nervous disorder?
☐ Yes	☐ No	(n)	Bone, muscle or joint disorders: e.g. arthritis?
☐ Yes	☐ No	(o)	Cancer?
☐ Yes	☐ No	(p)	Heart murmur?
☐ Yes	☐ No	(q)	Radiation therapy?
☐ Yes	☐ No	(r)	Prosthetic joints or valves?
☐ Yes	☐ No	(s)	Venereal disease?
☐ Yes	☐ No	(t)	A.I.D.S.?
☐ Yes	☐ No	(u)	Smoke?
☐ Yes	☐ No	(v)	Hepatitis – A – B – C?

7. ☐ Yes ☐ No Have you ever had abnormal bleeding associated with previous extractions, surgery or trauma?
(a) Do you bruise easily? _____

8. ☐ Yes ☐ No Do you have any blood disorder?

9. ☐ Yes ☐ No Women – are you pregnant or breast feeding?

10. ☐ Yes ☐ No Do you have any disease or problem not listed above you think I should know about?
(a) If so, please explain.

_____

11. What dental condition concerns you at present?

_____

I BELIEVE THE INFORMATION ON THIS FORM TO BE CORRECT AND TO PROVIDE A COMPLETE SUMMARY OF MY PAST OR PRESENT MEDICAL AND DENTAL STATUS.

I, THE UNDERSIGNED (PATIENT OR LEGALLY RESPONSIBLE PARTY), AUTHORIZE DENTAL TREATMENT TO BE RENDERED BY THE DENTIST AND HIS STAFF, AND ASSUME FINANCIAL RESPONSIBILITY.

Signature _____ Date _____

For office use: Details/Update

B.P. / Pulse: Resp.: