719 Bayshore Drive
Niceville, Fl 32578

EMERALD COAST PERIODONTICS
M. McClain Woolsey, D.D.S.

Phone: 850-678-6485
Fax: 850-678-5245

PATIENT REGISTRATION AND MEDICAL HISTORY

PLEASE PRINT AND COMPLETE ALL SECTIONS

Patient: _____
Last Name First Name Middle Initial Preferred Name/Nickname

Sex: ____Male ____Female **Single** ___ **Married** ___ **Widowed** ___ **Divorced**___

Social Security #_____ **Date of Birth:**_____**Age:**_____

Home Address:_____ **Home Phone:**_____

City_____**State**____**Zip**_____ **Cell No.** _____

Employer:_____ **Work No.**_____

Business Address:_____ **Occupation:**_____

Race: _White _Black/African American _Hispanic/Latino _Native American/Indian _Asian _Other_____

SPOUSE INFORMATION *OR* PARENT IF PATIENT IS A MINOR

Name:_____ **Birthdate:**_____

Employer:_____ **Social Security No.:**_____

Business Address:_____ **Business Phone:** _____

In Case of Emergency, Whom Should We Notify:_____**Phone:**_____

Name of General Dentist:_____ **Name of Medical Doctor:**_____

Whom May We Thank for Referring You?_____

Dental Insurance:_____Group No._____Policy No._____

Address:_____Policy Holder Name:_____Birthdate_____

If Group, Employer:_____Social Security No._____Relationship to Patient_____

Secondary Dental Insurance: _____Group No._____Policy No._____

Address:_____Policy Holder Name:_____Birthdate_____

If Group, Employer:_____Social Security No._____Relationship to Patient_____

ASSIGNMENT AND RELEASE

I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all of my insurance submissions whether manual or electronic. I acknowledge the payment is due at the time of treatment, unless other arrangements are made. I agree that parents/guardians are responsible for all fees and services rendered for treatment of a minor child. I accept full financial responsibility for all charges.

I also authorize Emerald Coast Periodontics, P.A. to release relevant patient information (x-rays, treatment plan, and account information, etc.) to my general dentist/medical doctor as well as to obtain any pertinent information needed from him/her.

_____ _____
DATE **SIGNATURE**

I, being the parent or guardian of _____ **(*name of child*) do hereby request and authorize the dental staff to perform necessary dental services for my child, including but not limited to x-rays and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment and when the treatment is rendered.**

_____ _____
DATE **SIGNATURE**

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MEDICAL HISTORY

NAME: _____ **Height:**_____ **Weight:**_____**Age:**_____

Year of last medical physical: _____ **Are you presently or this past year been under the care of a doctor?** ____**Yes** ___**No**

If yes, for what reasons _____

Physician's Name: 1._____City:_____

And Address: 2. _____City:_____

Do you premedicate with antibiotics? ___Yes ___No If so, Amoxicillin or Clindamycin or other: _____
For What? ___Heart ___Knee - right left ____Hip - right left __Other_____

Are you taking any drugs or medications? ___YES ___NO (check those that apply and specify name of drug)

__Blood pressure_____
__Blood thinners_____
___Aspirin 81mg. ___Aspirin 325mg
___Coumadin __mg ___Plavix
__heart _____
__antibiotics (penicillin, etc.)_____
__steroids (Prednisone)_____
__Synthroid
__Nitroglycerin
__antihistamines (Seldane, etc.)_____
__insulin (Orinase, etc.)_____
__oral medication for Diabetes_____
__tranquilizers _____

__Bisphosphonates: ___Fosamax Started: _____ Stopped:_____
___Boniva Started: _____ Stopped:_____
___Actonel Started: _____ Stopped: _____
__others: (please list) _____

Are you allergic or had reactions to? ___YES ___NO (check those that apply)

__Local anesthetics
__antibiotics (Penicillin, sulfa, etc.)
__Motrin, Advil, and other NSAIDS
___Aspirin
___Latex
___Narcotics (Codeine, Demerol, etc.) -
Others: (please list) _____
__nausea __vomiting __itching __breathing

Do you have or have you had any of the following diseases or conditions? (check those that apply)

__High blood pressure
__Bypass Surgery Year_____
__Stent placement x ___ Year_____
__Cardiac pacemaker Year_____
__Heart murmur
__Damaged/artificial heart valves
__Stroke Year_____
__Chest pains, angina
__Congenital heart disease
__Congestive heart disease
__Heart attack Year_____
__Atrial fibrillation
__Other heart condition
__ Previously took Fen-phen, Pondimin, Redux, or Fenfluramine
__asthma
Childhood/Adult
Hospitalized Year_____
__Shortness of breath
__emphysema
__tuberculosis (TB)
__persistent cough
__swollen ankles
__Osteoporosis
__Osteopenia
__stomach ulcers
__thyroid problems
__hives or skin rash
__sinus problems
__seizures or epilepsy
__fainting or dizzy spells
__diabetes: Type1__ Type2__
__Hepatitis: A, B, or C
__Liver disease
__alcoholism
__Drug addiction
__kidney trouble
__arthritis
__glaucoma
__serious trouble with dental treatment_____
__Problems with motion sickness
__anemia
__prolonged bleeding
__hemophilia
__other bleeding problems
__venereal disease
__HIV/AIDS
__joint prosthesis Location:_____
__mental problems
__depression
__cancer Location:_____
__radiation Year_____
__chemotherapy Year_____

__other diseases or conditions (please list)_____

Do you smoke or use tobacco? ___Yes ___No cigarettess (packs/day____) __cigars __pipe __chewing tobacco __snuff or dip
Did you smoke in the past? _____Yes _____No If so, when did you stop? Date: _____
Have you tried to stop? ___Yes ____No If so, have you used ___Nicotine patches ___Zyban ___Wellbutrin ___ Chantrix ___ Hypnosis

Females: __Pregnant (Trimester 1 – 2 – 3) __Nursing __oral contraceptives __menstrual period problems __hormone replacement therapy

I certify that I have read and understand the above. If I have any changes in my health, I will inform my doctor as soon as possible.

_____ _____
Patient's Signature **Date**

_____ _____ _____ _____
Blood pressure/pulse/date **Blood pressure/pulse/date** **Blood pressure/pulse/date** **Blood pressure/pulse/date**

Dentist's comments:

_____ _____
Dentist's Signature **Date**

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DENTAL INFORMATION

PATIENT NAME:_____ **DATE:**_____

Referred By: _____ If Dentist, how long have you been his/her patient?_____

If Dentist, when did you see him/her last? _____

DENTAL INFORMATION:

What is your major oral complaint?_____

What concerns you most regarding your teeth? (appearance, comfort, etc)?_____

DENTAL HISTORY:

Last dental cleaning (date)_____Location:_____ _____

Previous full mouth x-rays: Yes_____ No_____ When:_____ By Whom:_____

Previous Periodontal Surgery: Yes_____ No_____ Location:_____Date:_____

By Whom:_____

Previous Scaling/Root Planing: Yes_____ No_____ Location:_____Date:_____

By Whom:_____

Mother has/had Natural Teeth ___ Denture ___ Partial ___ Dx with gum disease ___

Father has/had Natural Teeth ___ Denture ___ Partial ___ Dx with gum disease ___

Previous Orthodontic treatment: Yes_____ No_____ Location:_____ Age:_____

CURRENT PROBLEM: Do you have?

Tooth Ache (at present time) Yes_____ No_____

If yes, where? Upper_____ back_____ R L front_____ How Long?_____

Lower_____ back_____ R L front_____ How Long?_____

If yes, sensitive to: Hot___ Cold___ Biting___ Spontaneous___ Awake from sleep___

Abscess on #____ Presently on antibiotics? Yes__ No__ How long?____If so, ___ Penicillin

___Clindamycin

___Other

PLEASE CHECK THE BOXES BELOW WHICH APPLY TO YOU:

- ☐ Bleeding gums
- ☐ Receding gums
- ☐ Food impaction
- ☐ Movement or drifting of teeth
- ☐ Unpleasant taste
- ☐ Swelling or lumps in mouth
- ☐ Bad breath
- ☐ Mouth breather
- ☐ Piercing of tongue or lips
- ☐ Wear biteguard __soft __hard
- ☐ Awaken with sore jaw muscles
- ☐ Limited jaw movement
- ☐ Clenching or grinding of teeth
- ☐ Dry mouth – use __Biotene __Other_____
- ☐ Prolonged bleeding following an extraction
- ☐ Frequent blisters on lips or in mouth

Frequency of brushing _____ Do you brush your tongue? ____yes ____no Frequency of Flossing_____

Make use of: ____power brush ____water pic ____Fluoride rinse

FOR CHILDREN ONLY (ORTHODONTICS)

Are you currently undergoing orthodontic care? Yes No