Daniel West, D.D.S., M.S.
WEST PERIODONTICS LLC

09/14

PATIENT'S NAME_____BIRTHDATE_____

HOME ADDRESS _____
STREET CITY STATE ZIP

_____
HOME# WK# CELL# E-MAIL

PATIENT'S SS# _____ MALE _____ FEMALE _____ SINGLE _____ MARRIED ____

EMPLOYER NAME/ADDRESS _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

NAME OF FAMILY DENTIST _____ DATE OF LAST CLEANING_____

NAME OF YOUR PHYSICIAN _____ PHONE# _____

NAME OF EMERGENCY CONTACT_____ PHONE#_____

ARE YOU ALLERGIC TO OR HAVE HAD A REACTION TO ANY OF THE FOLLOWING? (Please Check)

- □ Aspirin
- □ Codeine
- □ Fosamax
- □ Demerol
- □ Tylenol
- □ Motrin/Advil
- □ Iodine
- □ Local Anesthetic
- □ Valium
- □ Percodan
- □ Nitrous Oxide (laughing gas)
- □ Phenergan
- □ Thorazine
- □ Probanthine
- □ Penicillin
- □ Erythromycin
- □ Clindamycin
- □ Tetracycline
- □ Biaxin
- □ Cipro
- □ Keflex
- □ Other Antibiotics
- □ Latex Allergy
- □ Sulfa

ARE YOU ALLERGIC TO ANY OTHER MEDICATION? (Circle) Yes No If yes, please list_____

DO YOU SMOKE CIGARETTES? (Circle) Yes/ No If yes, how many packs per day_____

FOR WOMEN: Are you pregnant? (Circle) Yes / No Are you taking birth control pills? (Circle) Yes /No
(**Taking antibiotics may inactivate birth control pills)**

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING? (Please Check)

- □ Heart disease
- □ Heart attack
- □ Heart murmur
- □ Irregular heartbeat
- □ Mitral valve prolapse
- □ Artificial heart valve
- □ Heart pacemaker
- □ Heart surgery
- □ Orthopedic implant
- □ Organ transplant
- □ Acid Reflux
- □ Osteoporosis
- □ Osteopenia
- □ Stroke
- □ Kidney trouble
- □ Ulcers
- □ High blood pressure
- □ Emphysema
- □ Tuberculosis (TB)
- □ Asthma
- □ Sinus trouble
- □ Pollen allergies
- □ Diabetes
- □ Thyroid disease
- □ Epilepsy or seizures
- □ Cancer
- □ Arthritis
- □ Glaucoma
- □ Pain in jaw joints
- □ Excessive bleeding
- □ Anemia
- □ Alcoholism
- □ Substance abuse problem
- □ Neurologic disorder
- □ Psychiatric treatment
- □ Fainting or dizzy spells
- □ Hepatitis
- □ Liver disease
- □ Blood transfusion
- □ Hemophilia
- □ Bruise easily
- □ Sexually transmitted diseases
- □ Fever blisters (herpes)
- □ AIDS or related
- □ HIV or related
- □ Hearing disorder

DO YOU HAVE ANY OTHER MEDICAL CONDITIONS? (Circle) Yes No If yes, please list_____

_____

LIST ANY PRESCRIBED MEDICATIONS YOU ARE CURRENTLY TAKING _____

_____

ARE YOU PRESENTLY TAKING OR HAVE YOU IN THE PAST TAKEN: FOSAMAX, ACTONEL, BONIVA, ZOMETA OR A SIMILAR DRUG?
(Circle) Yes No If so, you may be at risk for osteonecrosis of the jaw (ONJ).

APPOINTMENTS: Once an appointment is made, please remember this time has been reserved for you.
Without 24-hour notification, you may incur a charge for failed or cancelled appointments.

PATIENT (OR GUARDIAN'S) SIGNATURE _____ DATE ___/___/____