LASER PERIODONTICS & DENTAL IMPLANTS
OF SOUTH CAROLINA

PATIENT INFORMATION

First Name: _____ Last: _____ Middle Initial: _____
Street Address: _____ Apt/Unit#_____
City: _____ State: _____ Zip: _____
Cell: _____ Home: _____ Work: _____ Ext: _____
Date of Birth: _____ SSN#: _____ Drivers Lic#: _____
Email: _____ Marital Status: _____ Sex: M / F
Pharmacy: _____ Occupation: _____
Emergency Contact name & phone number: _____

INSURANCE INFORMATION

Dental Insurance company: _____ Policy Holder: _____
Policy#: _____ SS# or ID#: _____ Group#: _____
Employer of policy holder: _____ Policy holder DOB: _____

DENTAL / MEDICAL HISTORY

General Dentist: _____ Referred by: _____
Last dental cleaning: _____ Do you go for regular visits? _____
Your physician: _____
Medications:_____

_____

Allergies / Reactions: _____
Do you take a **PREMED** before dental treatments? Yes / No If yes; what antibiotic? _____

Do you have, or have had any of the following? **Please provide history if yes.**
Hepatitis / Jaundice / Liver disease: _____ Joint Replacement: _____ Date: _____
AIDS / HIV positive: _____ Stomach Ulcers / Duodenal Ulcers: _____
Rheumatic fever / Heart murmur: _____ Kidney disease or Infection: _____
Heart Trouble / Stroke / Mitral valve prolapse: _____ Cancer: _____
High or Low Blood pressure: _____ Glaucoma / Prostate problems: _____
Diabetes: _____ Last A1C: _____ Anemia / Blood disorder / Clotting problems: _____
Asthma / Sinus problems: _____ Are you pregnant? _____
Epilepsy / Seizures: _____ Do you smoke? _____ How much? _____
Drug or Alcohol Dependency: _____ Arthritis / Rheumatism: _____
Have you been treated for osteoporosis? _____ What medication, when & how long taken? _____
Recent hospitalizations? _____

I certify that all the information above is correct: _____ Date: _____
SIGNATURE