MILLER KORN
SOUTH FLORIDA PERIODONTICS AND IMPLANT SOLUTIONS

Robert J. Miller, DMD
Randi J. Korn, DMD

Today's Date_____

Patient's Name _____Date of Birth _____Marital Status: _____

Home Address_____City_____State_____Zip_____

Cell Phone _____Home Phone_____Email_____

Employer_____Social Security #_____Dental Insurance Co._____

Name of Insured _____Relationship_____Insured DOB_____ Insured SSN _____

Patient's General Dentist _____City/State_____How Long _____

Patient's Medical Physician_____City/State_____How Long _____

Who referred you to this office _____Reason for today's visit_____

Since periodontal disease is produced by a combination of many complex elements, it is necessary to resolve every possible contributing factor. The success of therapy is most dependent upon this. Though some of the following questions may seem unrelated to your gum condition, they are all associated with proper management of your oral health. Your answers are for our records only and will be considered confidential.

Health History:

Are you in good health……Yes____No____

Date of last physical exam_____Are you currently being treated by a physician? …… Yes____No____

Are you taking any prescription drugs or medications……...... ...Yes____No____

If yes, please list_____

Are you taking any over-the-counter medications, vitamins and/or supplements……..Yes____No____

If yes, please list_____

Are you allergic to any of the following:

Local anesthetics "Novocaine"	Yes___No___	Asprin	Yes___No___
Barbiturates, sedatives, sleeping pills	Yes___No___	Codeine	Yes___No___
Penicillin	Yes___No___	Other	
Other antibiotics	Yes___No___		

Indicate which of the following you have had or have at the present: (all items **must** be checked yes or no)

AIDS/ARC/HIV	Yes___No___	Drug addiction	Yes___No___	Low blood pressure	Yes___No___
Alcohol addiction	Yes___No___	Emphysema	Yes___No___	Mental disorder	Yes___No___
Allergies or hives	Yes___No___	Epilepsy or seizure	Yes___No___	Mitral valve disorder	Yes___No___
Anemia	Yes___No___	Fainting or dizziness	Yes___No___	Osteoporosis	Yes___No___
Angina	Yes___No___	Fatigue	Yes___No___	Persistent cough	Yes___No___
Anxiety	Yes___No___	Glaucoma	Yes___No___	Prolonged bleeding	Yes___No___
Arthritis or rheumatism	Yes___No___	Heart disease or attack	Yes___No___	Radiation treatment	Yes___No___
Artificial heart valve	Yes___No___	Heart failure	Yes___No___	Recent weight loss	Yes___No___
Asthma	Yes___No___	Heart murmur	Yes___No___	Rheumatic or scarlet fever	Yes___No___
Blood disease	Yes___No___	Heart pacemaker	Yes___No___	Shortness of breath	Yes___No___
Blood transfusion	Yes___No___	Heart surgery	Yes___No___	Sinus trouble	Yes___No___
Bruise easily	Yes___No___	Hepatitis	Yes___No___	Skin disease	Yes___No___
Cancer	Yes___No___	High blood pressure	Yes___No___	Stroke	Yes___No___
Chemotherapy	Yes___No___	Hip or knee replacement	Yes___No___	Swollen ankles	Yes___No___
Chest pain	Yes___No___	Hypoglycemia	Yes___No___	Thyroid disease	Yes___No___
Cold sores/fever blisters	Yes___No___	Immune system disorder	Yes___No___	Tuberculosis	Yes___No___
Congenital heart lesions	Yes___No___	Kidney disorder	Yes___No___	Ulcers	Yes___No___
Diabetes	Yes___No___	Liver disorder	Yes___No___	Venereal disease	Yes___No___

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Health History Continued:

Have you had any serious illness, operation or have been hospitalized …….. Yes____No____

If yes, please explain_____

Do you have any disease, condition or problem…….. Yes____No____

If yes, please explain_____

In order to prevent complications associated with heart disease, heart murmur, artificial heart valve or artificial joint replacement, it is often necessary to take antibiotics prior to any dental appointment. Please contact your physician or our office before your first appointment if you have any questions regarding premedication. Do you normally premedicate…….. Yes____No____

Do you smoke or chew tobacco …….. Yes____No____

Do you consume alcohol on a regular basis……...Yes____No____

If yes, amount and frequency_____

Do you use recreational drugs……...Yes____No____

Health History for Women:

Are you pregnant ……...Yes____No____

Are you taking birthcontrol ……...Yes____No____

If yes, for how long_____

Have you reached menopause……...Yes____No____

Dental History:

Date of your last dental visit _____

Have you had any problems associated with previous dental treatment ……...Yes____No____

If yes, please explain_____

Have you ever worn braces……...Yes____No____

Do you clench or grind your teeth ……...Yes____No____

Do you experience pain in your jaw joints or facial muscles ……...Yes____No____

Do you wear any removable dental appliance ……...Yes____No____

When was the last time you had x-rays taken and where _____

I certify all the above given information to be true and accurate. The undersigned hereby authorizes the Doctors to perform all necessary procedures deemed appropriate to make a thorough diagnosis of the patients dental or oral-facial needs including x-rays, study models, photographs, medications and the use of local anesthetic agents. I understand that responsibility for payment of dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered, unless financial arrangements have been made. In the event of default, I promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

_____ _____

Signature of patient (Parent or guardian, if minor) Date