Welcome to the office of Joseph M. Perry, DDS Today's Date _____

Last Name _____ First Name _____ Middle _____

Preferred Name _____ Email Address _____

Home Address _____ Home Phone _____

City, State _____ Zip Code _____ Cell Phone _____

Employer _____ Dept/Shift _____ Work Phone _____

SS# _____ Date of Birth ___/___/___ Sex: Male _____ Female _____

Marital Status: Single Married Separated Divorced Widowed Minor Age _____ Grade _____

College name of student over 18 _____ FT / PT Immunizations up to date YES NO

Parent or Guardian name _____ Cell Phone _____

Full Custody _____ Joint Custody Name _____ Responsible Party _____

Emergency Contact /Relationship _____ Phone number _____

Are you currently covered by: Dental Insurance Reimbursement plan Flex Spending Plan Circle all that apply None

Please list Insurance information on the back and submit your current Dental insurance card for copying

Dental History: Date of last dental exam/cleaning _____ X-rays _____

Name of prior office _____ phone number _____

Do you take an antibiotic prior to your dental appointment? NO YES Rx _____

Reason: Joint Replacement, Heart Valve Surgery, Rheumatic Fever or Endocarditis? Per Dr. _____

Medical History: Date of last Physical exam _____ Name of Physician _____

Have you recently been under a Physician's care or hospitalized? Reason: _____

Do you use tobacco? YES NO Pipe/Cigar/Cigarette/Chew Do you use alcohol or drugs? YES NO _____

Are you **Allergic** to or suffer ill effects/Asthma from any of the following? No known Drug Allergies _____

_____ Dental Anesthesia _____ **Latex Gloves** _____ Penicillin _____ Aspirin

_____ Household Bleach _____ Nickel _____ Sulfa _____ Codeine

_____ Other _____

Put date started for all of the following that apply: **Do you carry an Epi-Pen or inhaler with you? YES** NO

_____ **Chemo/Radiation** _____ **Osteoporosis Rx** _____ HBP medication _____ Pain Medication

_____ **Blood thinners** _____ Steroids _____ Thyroid medication _____ Sedatives _____

List of Current Medications including vitamins and over the counter medications: _____

Circle any of the following that you have, had or suspect you have: Include year diagnosed or treated

YES	NO	**High Blood Pressure**	YES	NO	**Joint Replacement** _____	YES	NO	Headaches
YES	NO	Chest Pains			Hip R L Knee R L _____	YES	NO	Mental Health Disorders
YES	NO	Heart Attack w/wo surgery	YES	NO	Blood Transfusion _____	YES	NO	Nervous / Dental Phobic
YES	NO	**Bacterial Endocarditis**	YES	NO	Bleeding Disorder	YES	NO	Trouble with your TMJ
YES	NO	Rheumatic Fever/ MVP	YES	NO	Prolonged Bleeding	YES	NO	Difficulty Chewing
YES	NO	Heart Valve surgery	YES	NO	Anemia	YES	NO	Facial Trauma / surgery
YES	NO	Congestive Heart Failure	YES	NO	HIV or AIDS	YES	NO	Sensitive Teeth
YES	NO	**Pacemaker/Defibrillator**	YES	NO	Diabetes at Age _____	YES	NO	Bite your Lips or Cheeks
YES	NO	**Stroke** Year _____	YES	NO	Jaundice or Hepatitis _____	YES	NO	Difficult Extraction
YES	NO	Swollen Ankles	YES	NO	Liver Disorder	YES	NO	Gums that Bleed
YES	NO	Emphysema/COPD	YES	NO	Thyroid Hypo / Hyper	YES	NO	Periodontal(Gum) Disease
YES	NO	Tuberculosis	YES	NO	Kidney or Bladder Disorder	YES	NO	Oral Cancer _____
YES	NO	Shortness of Breath	YES	NO	Asthma / Allergies	YES	NO	Venereal Disease/Herpes
YES	NO	Cancer _____	YES	NO	Sinus Trouble	YES	NO	Orthodontic Treatment
YES	NO	Radiation or **Chemo**	YES	NO	Fainting Tendency	YES	NO	Removable Partial/Denture
YES	NO	Osteoporosis	YES	NO	Epilepsy or Seizures	YES	NO	Fixed Bridge _____
YES	NO	**Oral/IV Osteoporosis Rx**	YES	NO	Eating Disorder	YES	NO	Dental Implant
YES	NO	Arthritis	**Other MEDICAL ALERTS**					

Women Only: Are you Pregnant? YES NO How many months? _____ Are you breastfeeding? YES NO

Are you currently taking : Oral Birth Control, Hormone Shots / Therapy? _____ YES NO

The above information is true to the best of my knowledge. Sign _____ Date _____