MARK EDWARDS D.D.S., P.A. **ANGELA WILSON D.D.S., M.S.**
Practice Limited to Periodontics
4830 Quail Crest Place
Lawrence KS 66049
785-843-4076

Please Complete Front and Back

Name_____Date_____

Address_____ City_____State_____Zip_____

Social Security_____Sex M F Marital Status S M D Date of Birth_____

Employer_____Work Phone_____Home Phone_____Cell Phone_____

Spouse's Name_____Spouse's Employer_____Your email address_____

Physician's Name_____Address_____Physician's Phone_____

Last Physical Examination_____Findings_____

Dental Insurance Company_____Policy # _____Group #_____

Referred by:_____Have family or friends been treated here?_____

Emergency contact name, phone #, and relationship:_____

Present Dental Concerns/Dental History Notes

_____

DENTAL HISTORY

	YES	NO
Do you fear dental treatment	____	____
Do your gums bleed	____	____
Do you grind or clench your teeth	____	____
Have you noticed your bite changing . . .	____	____
Have you been treated for periodontal disease	____	____
Have you had treatment to straighten your teeth	____	____
Has any member of your family lost all of their teeth	____	____
Have you had any "gum boils" or swellings	____	____
Are you satisfied with the appearance of your teeth	____	____

If no, why not_____

Are your teeth sensitive to hot___cold___sweet____

When was your last dental cleaning_____

What interval are you having your teeth cleaned (please circle)
3 months 4 months 6 months 12 months

How long have you been a patient of your present dentist _____

How long have you known of your present gum condition_____

Please circle how your would rate your past dental care:
good fair poor

Please check any of the following items you use in mouth care:

Hand toothbrush	___	Stimudents	___
Electric toothbrush	___	Gum stimulator	___
Proxabrush	___	Rubber tip	___
Tooth pick	___	Perio aid	___
Water spray device	___	Floss	___

Brushing frequency _____
Flossing frequency _____

MEDICAL HISTORY

	YES	NO
Hepatitis, jaundice, or liver disease	____	____
Epilepsy, convulsion, fainting spells	____	____
Heart murmur	____	____
Heart trouble or stroke	____	____
High blood pressure	____	____
Arteriosclerosis	____	____
Shortness of breath	____	____
Emphysema	____	____
Chest pain	____	____
Swelling in ankles	____	____
Tuberculosis	____	____
Kidney disease or infection	____	____
Diabetes	____	____
Any blood relative	____	____
Arthritis or rheumatism	____	____
Stomach or gastric disorder	____	____
Glaucoma	____	____
Asthma, hay fever, or allergies	____	____
Drug reaction to: codeine, demerol	____	____
percocet, percodan	____	____
aspirin, valium, nitrous oxide	____	____
tetracycline, penicillin, erythromycin	____	____
LATEX	____	____
other _____	____	____
Thyroid or parathyroid disease	____	____
Venereal disease	____	____
HIV/AIDS	____	____
Hospitalization for illness or surgery	____	____
Hives or skin rash	____	____
Cancer or abnormal growth	____	____
If yes, did you have radiation treatment or chemotherapy	____	____
Anemia or blood disorder	____	____
Abnormal bleeding problems	____	____
Do you have an artificial prosthesis	____	____
Do you require antibiotic premedication prior to dental procedures	_____	____

	YES	NO
Substance abuse/alcoholism	____	____
Do you take aspirin, anticoagulants (blood thinners), fish oil, Omega 3, or flaxseed	____	____
Do you wear contact lenses	____	____
Do you bruise easily	____	____
Do you smoke	____	____
If so, how much _____ How many years _____		
If male, prostate problems	____	____
If female:		
Pregnant or lactating	____	____
Taking anti-pregnancy drug	____	____
Presently in menopause	____	____
Post-menopause	____	____
Osteoporosis/osteopenia	____	____
Taking medications for osteoporosis/osteopenia (i.e. Fosamax, other bisphosphonates) _____	___	___
Any serious illness not listed	____	____
Would you desire nitrous oxide (laughing gas) sedation	____	____

Are you:		
Presently under a physicians care	____	____
Taking any medication not listed	____	____
Taking vitamins	____	____
Allergic to dental anesthetic	____	____
Aware of recent weight change	____	____
Often exhausted or fatigued	____	____
Subject to frequent headaches	____	____
A nervous person	____	____
Under unusual stress or tension	____	____
Taking nerve or sleeping pills	____	____
Often unhappy or depressed	____	____
Taking antidepressant medication	____	____
Taking herbal supplements	____	____

Medical History Notes

_____

_____

_____

_____

_____

_____

_____

Please write below or attach a list of current medications and dosage: (including over the counter medications)

_____

_____

_____

_____

_____

_____

_____

Patient signature (parent signature if minor) _____