Virginia Perio
PERIODONTICS AND DENTAL IMPLANTS

10320 Memory Lane, Suite A
Chesterfield, Virginia 23832
(804) 748-9553
FAX (804) 748-0460

Patient Information (PLEASE PRINT)

Patient's Full Name _____ Age_____ Date of Birth _____ Sex_____

Address_____ County Of_____

City, State, and Zip Code_____ Social Security No._____

Patient's Employer_____ Home Phone_____

Address_____ Cell Phone_____

Spouse's Name_____ Office Phone_____

Spouse's Employer_____ Email Address_____

Spouse's Work Address_____ Spouse's Work Phone No._____

Whom may we contact in case of an emergency?_____ Phone No._____

Who is financially responsible for this bill?_____

Address_____

Phone No._____ Whom may we thank for referring you to us?_____

HAVE YOU HAD ANY OF THE FOLLOWING? (Please circle YES or NO)

Heart Murmur	YES	NO	Anemia	YES	NO
Rheumatic Fever	YES	NO	Asthma or Hay Fever	YES	NO
Diabetes	YES	NO	Epilepsy or Seizures	YES	NO
Heart Condition	YES	NO	Lung Disorders (T.B. or Emphysema)	YES	NO
Abnormal Blood Pressure ☐ High ☐ Low	YES	NO	Thyroid Disorder	YES	NO
Bleeding Disorder	YES	NO	Arthritis	YES	NO
Hepatitis	YES	NO	Glaucoma	YES	NO
Stomach Ulcers	YES	NO	Psychiatric Treatment	YES	NO
Bleeding Gums	YES	NO	HIV/Aids	YES	NO
Jaundice or Liver Disorder	YES	NO	Do you use tobacco?	YES	NO

Are you presently under the care of a physician? ◯ YES ◯ NO
Explain_____

Have you ever had any serious illness or operation? ◯ YES ◯ NO
Explain if yes_____

Are you allergic to any foods or medications? ◯ YES ◯ NO
Explain_____

Has anyone in your family had diabetes? ◯ YES ◯ NO

lf female, are you pregnant at this time? ◯ YES ◯ NO
lf so, which month?_____

Are you taking any medication now? ◯ YES ◯ NO

Please list and for what purpose?

Have you ever taken or are you taking:

Cortisone	◯ YES	◯ NO	Anticoagulants (blood thinners)	◯ YES	◯ NO
Tranquilizers	◯ YES	◯ NO	Nitroglycerine	◯ YES	◯ NO
Digitalis	◯ YES	◯ NO	Oral Contraceptives or Hormones	◯ YES	◯ NO

When was the last time you were treated by your dentist?_____

What was done at the time?_____

Have you ever had any complications associated with previous dental treatment?
Explain_____

Do you have any condition in your mouth that is causing you discomfort or concern?
_____

I fully understand that I am financially responsible for all fees not covered by my insurance company.

_____	_____	_____
Patient's Signature	Name	Date
_____	_____	_____
Parent's signature if patient is a minor	Name	Date