Dr. David P. Violette
Periodontal Therapists: Pam Buck, RDH Laura Cassidy, RDH Ruthann Stover, RDH
34 North Main Street W. Bridgewater, MA 02379 (508) 583-5338

MEDICAL-DENTAL PROFILE

PATIENT NAME Mr Mrs Ms Dr_____ **Date of Birth**_____ **Today's Date**_____
HOW WOULD YOU PREFER TO BE ADDRESSED?_____**OCCUPATION** _____
PHYSICIAN_____ Town_____ or Office Phone_____
Approximate date of last **COMPLETE PHYSICAL EXAM**_____
HOSPITALIZATIONS OR SURGERIES within the past 6 months _____
Approximate date of last **DENTAL CHECKUP** _____
MEDICATIONS: Please list **medicines** you take and the **conditions** for which you take them (prescription, non-prescription, supplements, vitamins)_____
_____
Are you taking or have you ever taken **Bisphosphonates** (Fosamax, Actonel, etc. to treat osteoporosis/osteopenia)? YES NO
ALLERGIES: (please circle) Penicillin Codeine Novocaine Latex Other (please list)_____
_____
Do you play **SPORTS?** YES NO If YES, do you wear an athletic **MOUTHGUARD?** YES NO
WOMEN: Are you **Pregnant?** YES NO Are you **Nursing?** YES NO Are you taking **Birth Control Pills?** YES NO

Do any of the following conditions apply or have they in the past applied to you? (Circle YES or NO)

YES	NO	Arthritis	YES	NO	Heart Defect
YES	NO	Artificial Heart Valve	YES	NO	Heart Disease – Heart Attack or Angina
YES	NO	Artificial Hip, Knee or Shoulder Joint	YES	NO	High Blood Pressure
YES	NO	Asthma	YES	NO	Hepatitis A B C
YES	NO	Blood Disorder – Prolonged Bleeding	YES	NO	Kidney Disease
YES	NO	Cancer	YES	NO	Lung Disease
YES	NO	Chronic Obstructive Pulmonary Disorder	YES	NO	Oral Herpes / Cold Sores
YES	NO	Compromised Immune System (AIDS, HIV+)	YES	NO	Osteoporosis or Osteopenia
YES	NO	Diabetes	YES	NO	Pacemaker
YES	NO	Eating Disorder (Anorexia or Bulimia)	YES	NO	**Premedication** Before Dental Treatment
YES	NO	Emphysema	YES	NO	Radiation Therapy to the Head and Neck
YES	NO	Epilepsy or Seizures	YES	NO	Stroke
YES	NO	Fainting Spells	YES	NO	Thyroid Problems
YES	NO	Head Injuries	YES	NO	Tuberculosis

Please answer the following questions: (circle Yes or No)

YES NO Are you currently wearing partial or full **DENTURES** or do you have any dental **IMPLANTS?**
YES NO Do you **SMOKE** or **CHEW TOBACCO?**
YES NO Do you have a history of **Excessive Alcohol Consumption** or **Substance Abuse?**
YES NO Have you ever used **Fen-phen** (or other prescribed diet medicines)?
YES NO Have you ever had a **BAD REACTION** to **NOVOCAINE** for dental procedures?
YES NO Do you suffer from **TMJ DYSFUNCTION** (jaw pain)
YES NO Do your jaws ever feel **TIRED** because you **GRIND** or **CLENCH** your teeth?
YES NO Do your **GUMS BLEED** when you brush, floss or use a toothpick?
YES NO Are your gums **RED, SWOLLEN, TENDER** or **RECEDING?**
YES NO Do you suffer from persistent **BAD BREATH?**
YES NO Do you **BRUSH** your teeth at least **TWICE** a day?
YES NO Are you using a **SOFT-BRISTLED** toothbrush?
YES NO Do you **FLOSS** your teeth at least **ONCE** a day?
YES NO Do you **CLEAN YOUR TONGUE?**
YES NO Are you happy with your **SMILE?**

Please list any other **medical** or **dental** conditions, information or concerns you may have: _____
_____
_____

I certify that, to the best of my knowledge, the above "Protected Health Information" is truthful, accurate and complete. I authorize the release of this information as well as exam, diagnosis and treatment records of services rendered to me to third party payers and/or health practitioners as is necessary. I acknowledge that this office is in compliance with HIPAA Privacy Regulations and that a copy of their Privacy Practices Notice is available to me upon request at any time.

Patient Signature (or Representative)X _____Relationship to patient_____Date_____