BARRY W. HEATON DDS
PERIODONTICS
DENTAL IMPLANT SURGERY
BOARD CERTIFIED

Patient Demographics

10260 Westheimer Rd., Suite 510
Westheimer @ Beltway 8
Houston, Texas 77042
713-339-2800

Last _____ First _____ Middle _____

Preferred _____ Title _____ ❑ Male ❑ Female ❑ Single ❑ Married ❑ Child ❑ Other

Birth Date _____ S.S.# _____ Drivers License # _____

Address _____

Address _____

City _____ State _____ Zip _____

E-mail _____ Home Phone _____

Work Phone _____ Ext. _____ Best time to call _____

Fax _____ Pager/Cell _____ Other _____

Employer Information

Employer Name _____ Phone _____

Address _____ Occupation _____

Address _____

City _____ State _____ Zip _____

Dental Insurance Information

Primary

Name of Insured _____ Is insured a patient? ❑ Yes ❑ No

Birth Date _____ ID# or SSN _____ Group# _____

Insured's Employers Name _____ Phone# _____

Patient's relationship to insured ❑ Self ❑ Spouse ❑ Child Other _____

Insurance Plan Name _____

Address _____ City _____ State _____ Zip _____

Phone # _____

Whom may we thank for referring you to our practice? _____

Phone# _____

In case of emergency, please contact Name _____

Home Phone _____ Work Phone _____

Medical History

Do you now or have you ever had any of the following? **Please answer yes or no to ALL questions**.
* If yes to any of the starred conditions, please call prior to your appointment, premedication may be required.

	Yes	No		Yes	No		Yes	No
Anemia	❑	❑	Fainting Tendency	❑	❑	Lung Disease	❑	❑
Angina/Chest Pain	❑	❑	Fever Blisters	❑	❑	Mitral Valve Prolapse*	❑	❑
Artificial Heart Valve*	❑	❑	Frequent Cough	❑	❑	Nervousness	❑	❑
Aspirin Therapy (Taken Daily)	❑	❑	Frequent Diarrhea	❑	❑	Pain in Jaw Joints	❑	❑
Asthma	❑	❑	Glaucoma	❑	❑	Plavix	❑	❑
Alzheimer's Disease	❑	❑	Grind Teeth	❑	❑	Psychiatric Care	❑	❑
Arthritis/Gout	❑	❑	Heart Attack/Failure	❑	❑	Recent Blood Transfusion	❑	❑
Artificial Joint*	❑	❑	Heart Murmur*	❑	❑	Renal Dialysis	❑	❑
Bleeding Tendency	❑	❑	Heart Pacemaker*	❑	❑	Rheumatic/Scarlet Fever*	❑	❑
Blood Disease	❑	❑	Heart Problems	❑	❑	Rheumatoid Arthritis	❑	❑
Breathing Problem	❑	❑	Heart Surgery	❑	❑	Seizures or Epilepsy	❑	❑
Bruise Easily	❑	❑	Hemophilia	❑	❑	Shortness of breath when lying down	❑	❑
Cancer; Type _____	❑	❑	Hepatitis Circle one A B C	❑	❑	Sickle Cell Anemia	❑	❑
Chemotherapy	❑	❑	Herpes	❑	❑	Sinus Trouble	❑	❑
Cold Sores	❑	❑	HIV/AIDS	❑	❑	Stomach/Intestinal Disease	❑	❑
Congenital Heart Disorder	❑	❑	High Blood Pressure	❑	❑	Stroke	❑	❑
Convulsions	❑	❑	High Cholesterol	❑	❑	Thyroid Disease	❑	❑
Cortisone Medication	❑	❑	Hives	❑	❑	Tuberculosis	❑	❑
Coumadin	❑	❑	Hypoglycemia	❑	❑	Tumors or Growths	❑	❑
Diabetes/Family History of Diabetes	❑	❑	Kidney Problems	❑	❑	Ulcers	❑	❑
Drug Addiction/Alcoholism	❑	❑	Leukemia	❑	❑	Women (Taking Oral Contraceptives?)	❑	❑
Emphysema	❑	❑	Liver Problems	❑	❑	X-Ray Treatments (Radiation)	❑	❑

Have you ever had any other serious illness not checked above? Discuss _____

	Yes	No		Yes	No
Is your past and present health good?	❑	❑	Do you ❑ smoke ❑ chew ❑ dip	❑	❑
Are you pregnant/nursing?	❑	❑	Have you ever had to premedicate with antibiotics		
Are you allergic to any medications?	❑	❑	prior to Dental Care?	❑	❑

❑ Aspirin ❑ Penicillin ❑ Codeine ❑ Acrylic ❑ Metal
❑ Latex Rubber ❑ Dental anesthesia, gas or novocaine
❑ Other _____

Dental- Periodontal History

	Yes	No		Yes	No
Have you ever been treated for periodontal problems before? If so, when? _____	❑	❑	When was your last Dental Cleaning? _____		
Unpleasant taste and/or odor in your mouth?	❑	❑	Do you have pain/sensitivity in your teeth?	❑	❑
Is there any family history of periodontal problems?	❑	❑	Brush _____ times a day with:		
Do your gums bleed?	❑	❑	❑ Soft ❑ Medium ❑ Hard brush.		
Do you have pain in your gums?	❑	❑	Is your toothbrush hand held or electric? _____		
Do you gag easily?	❑	❑	Floss _____ times a day with:		
Do your gums feel swollen?	❑	❑	❑ Unwaxed ❑ Waxed ❑ by Hand ❑ Holder		
			Brush & floss: ❑ Morning ❑ Noon ❑ After Dinner ❑ Bedtime		

Please list any medications you are taking and their dosages: _____

_____

Physician's name/phone # _____ Date of last physical examination _____

Is there any other medical information that we should know that would be pertinent to our treating you? _____

_____

To the best of my knowledge, all of the preceeding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor at the next appointment without fail. I, the undersigned (Patient or Legal Guardian), authorize Periodontal Treatment to be rendered and assume financial responsibility.

Signature _____

Date _____