Jaeger Periodontics
1128 Route 31
Lebanon, NJ 08833
Tel: (908) 735-2722
www.jaegerperiodontics.com
LANAP Laser Periodontal Therapy

PLEASE PRINT

Female___ Male___ (Please check one)

Date_____ Birth Date_____

Name_____ Spouse's Name_____

Street address _____City_____

State_____ Zip Code_____

Home Phone _____Cell _____ Work_____

I authorize Jaeger Periodontics to leave a message at: (please check all that apply)

Home Phone _____Cell _____ Work_____

e-mail_____ Occupation_____

Referred by _____

Dentist Name_____ Address_____

Physician's Name_____ Address _____

Name of Parent(s) (if patient is a minor)_____

Present Complaint_____

Dental Insurance and Address_____

Subscriber's Name_____ Subscriber's Date of Birth _____

Place of Employment of subscriber_____

SS/Plan ID No. _____Group No._____

Secondary Insurance_____

Secondary Subscriber's Name _____Date of Birth _____

In case of emergency (close relative, not same residence) Name _____

Address_____ Phone no._____

PLEASE COMPLETE REVERSE SIDE

YES NO

___ ___ Are you presently under a physician's care?

___ ___ Have you had a recent physical exam?

___ ___ Are you taking any medicine at the present time? List medications, including homeopathic or “natural” remedies:
_____

___ ___ Do you take vitamins or herbs? _____

___ ___ Have you ever been seriously ill?

___ ___ Have you ever had abnormal or excessive bleeding?

___ ___ Have you had any adverse reaction to "Novocaine" or local anesthetics or serious trouble related to previous dental treatment?

___ ___ Do you take aspirin on a regular basis?

___ ___ Do you take Fosamax, Bonna, Actonel, Aredia or any bisphosphonate medication for the treatment of osteoporosis?

___ ___ Do you smoke? If so, how much_____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING:

___ ___ Allergies, (including latex) or Hives

___ ___ Asthma

___ ___ Sensitivity to particular medicine (aspirin, penicillin, tetracycline, codeine, erythromycin)

___ ___ Diabetes or family history of diabetes

___ ___ Damaged heart valves, artificial valves or heart murmur

___ ___ Heart trouble, heart attack, angina, high blood pressure, stroke, arteriosclerosis, rheumatic heart disease or any other heart condition

___ ___ Irregular heart beat or atrial fibrillation

___ ___ Do you wear a cardiac pacemaker?

___ ___ Respiratory problems, emphysema, persistent cough, etc.

___ ___ Rheumatoid arthritis

___ ___ Kidney trouble or disease

___ ___ Cancer or treatment for a tumor or growth

___ ___ Anemia or other blood disorder

___ ___ Ulcers or other stomach trouble (Irritable Bowel, Crohn’s Disease)

____ ___ Thyroid problems

___ ___ AIDS or HIV positive

___ ___ Hepatitis or liver disease

____ ___ Tuberculosis

____ ___ Fainting spells or seizures, epilepsy

____ ___ Alcohol/Drug addictions

___ ___ Joint replacement

___ ___ Nervous disorders

____ ___ Women, are you pregnant or nursing?

Do you have any other condition not listed? _____

DATE_____SIGNATURE_____REV.`1 7