DR. KARL "TONY" ROSE
Periodontal & Implant Associates
OF GREATER WASHINGTON

(301) 637-5318
5454 WISCONSIN AVENUE #620
CHEVY CHASE, MD 20815

PERSONAL INFORMATION

Please complete the following confidential questionnaire.

Name:_____ Date: _____

Date of Birth:_____ Home Address:_____

City:_____ State:_____ Zip:_____ Home Phone: (_____)_____

Work Phone: (_____)_____ Email:_____

Employer:_____

City:_____ State:_____ Social Security #:_____

Emergency Contact:_____ Relationship:_____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone: (_____)_____ Work Phone: (_____)_____

Is there anything you would like us to know about you?_____

_____

Have we treated any of your family or friends? If so, who?_____

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

ACCOUNT INFORMATION

Who is responsible for your account with our office?

Name:_____ Home Address:_____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone: (_____)_____ Work Phone: (_____)_____

Relationship to Patient:_____ Social Security #:_____

DENTAL HISTORY

Are you in discomfort that requires immediate attention? ☐ Yes ☐ No If yes, please explain:_____

_____

Are you under the care of a dentist? ☐ Yes ☐ No If so, who?_____

Is he or she your regular dentist? ☐ Yes ☐ No If not, who is?_____

Have you been treated for periodontal disease in the past? ☐ Yes ☐ No
Have you ever had orthodontic treatment (braces)? ☐ Yes ☐ No
Does heat, cold, or sweets cause pain or sensitivity in your mouth? ☐ Yes ☐ No
Are you apprehensive about your dental status or treatment? ☐ Yes ☐ No

MEDICAL HISTORY

If there has been any change in your health in the last year, please specify:_____

_____

_____

If you are currently under the care of a physician, please explain:_____

_____

_____

Physician's Name:_____ Phone: (_____) _____

Address:_____ City:_____ State:_____ Zip:_____

If you are currently taking any medications, please list them here:_____

_____

Are you allergic to, or have you ever had a reaction to any of the following drugs? Check those that apply:

- ☐ Penicillin
- ☐ Demerol
- ☐ Carbocaine
- ☐ Iodine
- ☐ Erythromycin
- ☐ Codine
- ☐ Vicodin
- ☐ Novacaine
- ☐ Latex
- ☐ Tylenol
- ☐ Epinephrine
- ☐ Xylocaine
- ☐ Percoset
- ☐ Barbituarates
- ☐ Aspirin
- ☐ Tetracycline
- ☐ Valium
- ☐ Sulfa
- ☐ Advil/Motrin
- ☐ Other: _____

Do you or have you had any of the following conditions? Check those that apply:

- ☐ HIGH BLOOD PRESSURE
- ☐ GLAUCOMA
- ☐ CANCER, TUMOR OR GROWTH
- ☐ STROKE
- ☐ LIVER OR KIDNEY DISEASE
- ☐ IMPLANTS/ARTIFICIAL JOINTS
- ☐ ASTHMA/LUNG DISEASE
- ☐ ORGAN TRANSPLANT
- ☐ ARTHRITIS
- ☐ ORAL ULCERS/FEVER BLISTERS
- ☐ THYROID PROBLEMS
- ☐ HEART MURMUR
- ☐ RHEUMATIC FEVER
- ☐ CHEMOTHERAPY
- ☐ BLOOD DISORDERS/ANEMIA
- ☐ HEPATITIS
- ☐ TUBERCULOSIS
- ☐ PSYCHIATRIC THERAPY
- ☐ SINUS PROBLEMS
- ☐ AIDS/HIV
- ☐ HEART DISEASE
- ☐ PROLAPSED VALVE
- ☐ RADIATION TREATMENT
- ☐ BLEEDING PROBLEMS
- ☐ DIABETES
- ☐ EPILEPSY
- ☐ ALCOHOL/DRUG ABUSE
- ☐ WEIGHT REDUCTION VIA REDUX/FEN PHEN

Do you use Tobacco? ☐ Yes ☐ No If yes, what form?_____How long?_____How much?_____

WOMEN: Are you pregnant? ☐ Yes ☐ No If yes, your expected due date:_____

Are you nursing? ☐ Yes ☐ No Are you taking birth control pills? ☐ Yes ☐ No

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Patient Signature:_____ Date:_____

Doctor's Signature:_____ Date:_____

Print Form

Remarks (for office use only):_____

_____

_____

_____

_____

_____