OFFICE USE ONLY

Dr. L. _____
N.P.L. _____
Sx. L. _____
Final _____
T.Y. _____

MURRAY L. RABALAIS, JR., P.D., D.D.S.
PERIODONTICS
A Professional Corporation

Name _____ SS# _____ Birth Date _____
Address _____ City _____ Zip _____
Home Phone _____ Office Phone _____ Marital Status _____
Cell Phone _____ Email _____ Fax _____
Occupation _____ Title _____ Occupation (Spouse) _____
Business Name & Address _____
Dentist's Name _____ Referred To This Office By _____
In Case of Emergency Notify _____ Relation _____ Phone _____
Approximate Date of Your Last Medical Appointment _____
Name of Physician _____ Physician's Address (city) _____
Dental Insurance: Yes _____ No _____ Major Medical Insurance: Yes _____ No _____

1. Are you in good GENERAL HEALTH? ..... Yes No
2. Have you ever had excessive bleeding from wounds or extractions? ..... Yes No
3. Has a physician ever told you that you have heart trouble? ..... Yes No
4. Do you get short of breath easily? ..... Yes No
5. Have you gained or lost much weight recently? ..... Yes No
6. Are you taking any medicine at the present time? (Oral contraceptives, Aspirin, Vitamins, etc.) .... Yes No
   What? _____
7. Are you allergic to any medicines? (Such as Penicillin, Codeine, Tylenol, Local anesthetics, etc.) .. Yes No
   What? _____
8. Have you had any surgical operations? (Such as Appendectomy, Hysterectomy, Tonsillectomy, etc.) Yes No
   What? _____
9. Do you have or you had:

Diabetes	Yes	No	Anemia	Yes	No
Rheumatic fever	Yes	No	Asthma	Yes	No
Liver trouble (Hepatitis)	Yes	No	Kidney trouble	Yes	No
High blood pressure	Yes	No	Allergies	Yes	No
Females - Are you pregnant?	Yes	No	Nervousness	Yes	No
Any Diabetes in your family?	Yes	No	Artificial Joints	Yes	No
Mitral Valve Prolapse	Yes	No	Osteoporosis	Yes	No

10. Have you ever taken medication for Osteoporosis? ..... Yes No
11. Have you ever had Chemotherapy ..... Yes No
12. Any other health condition? _____
13. Are you under abnormal stress? (Marital, Business or Social) ..... Yes No
14. Do you have any prosthetic joints (such as knee or hip replacement)? ..... Yes No
15. Have you ever been told to take antibiotics before dental treatment? ..... Yes No

DENTAL HISTORY

1. Are you having dental pain? ..... Yes No
2. Do you have any sores or swollen areas in your mouth? ..... Yes No
3. Does food pack between your teeth? ..... Yes No
4. Do your gums bleed when you brush your teeth? ..... Yes No
5. Have you ever had periodontal treatment? (Scalings, Surgery, etc.) ..... Yes No

6. How often do you visit the dentist? _____

7. What is your chief complaint concerning your mouth or teeth? _____

Signature _____ Date _____