PALM BEACH
PERIODONTICS

Patient Information

- **Full Name:** _____
- **Date of Birth:** ___ / ___ / _____
- **Gender:** Male ☐ Female ☐ Other ☐ Prefer not to say
- **Phone Number:** _____
- **Email Address:** _____
- **Home Address:** _____
- **Emergency Contact Name & Phone:** _____

Insurance Information

- **Insurance Provider:** _____
- **Policy Number:** _____
- **Group Number:** _____
- **Primary Policy Holder (if not patient):** _____

Dr. Jason Wong
Dr. Russell Gornstein
Dr. Megan Leyva

West Palm Beach: 561-967-0476
Boynton Beach: 561-734-2001
office@palmbeachperio.com

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Medical History

Do you currently or have you ever had the following? (Check all that apply)

- ☐ Low Blood pressure
- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Congeestive Heart Failure
- ☐ Emphysema
- ☐ Diabetes (Last HbA1C_____)
- ☐ Anemia
- ☐ Blood transfusion
- ☐ Currently on Blood Thinners
- ☐ Stroke
- ☐ Hepatitis A
- ☐ Hepatitis C
- ☐ Tuberculosis
- ☐ Cold Sores
- ☐ Liver Disease
- ☐ Epilepsy (Seizures)
- ☐ Recreational Drug Use
- ☐ Tobacco use
- ☐ Heart Disease
- ☐ Rheumatic Fever
- ☐ Stroke
- ☐ Angina or Heart attack
- ☐ Heart Surgery
- ☐ Asthma / Lung Conditions
- ☐ Hyper- or Hypo-thyroid
- ☐ Leukemia
- ☐ Excessive bleeding when cut
- ☐ Kidney Infections or Diseases
- ☐ Currently on Dialysis
- ☐ Hepatitis B
- ☐ HIV/AIDS
- ☐ Sexually Transmitted Infection
- ☐ Frequent Fainting
- ☐ Glaucoma
- ☐ Cancer (type: _____)
- ☐ Osteoporosis

Other major illnesses:_____

Allergies Please List:_____

Surgeries / Hospitalizations:

_____

Current Medications (including over-the-counter):

_____

_____

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Primary Care Physician: _____

Specialists: _____

Lifestyle Information

- **Do you smoke?** ☐ Yes ☐ No
- **Do you drink alcohol?** ☐ Yes ☐ No
- **Do you exercise regularly?** ☐ Yes ☐ No
- **Occupation:** _____

Reason for Visit

Consent & Signature

I certify that the above information is true and complete to the best of my knowledge.

Patient / Guardian Signature: _____ Date: ___ / ___ / _____

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