

PATIENT INFORMATION

Last Name _____ Home Phone _____
First Name _____ Work Phone _____
Middle Initial _____ Honoric _____ Birth Date (MM/DD/YY) _____
Nickname _____ Place of Employment _____
Address _____ Marital Status _____
City _____ Spouse Name _____
State _____ Zip _____ Spouse's Work # _____
Sex _____ Referring Dentist _____
E-Mail _____ Social Security # _____

BILLING INFORMATION

Last Name _____ SS# _____
First Name _____ Home Phone _____
Middle Initial _____ Work Phone _____
Address _____ Occupation _____
Relationship to Patient _____ Self _____ Parent _____ Guardian _____

DENTAL INSURANCE INFORMATION

Employee Name _____ Employer _____
Employee SS# _____ Group Plan _____
Employee Birth Date _____ Group No. _____
Relation to Employee _____ Self _____ Spouse _____ Child _____ Other _____

(Please give your insurance card to the receptionist so we can make a copy)

DENTAL HISTORY

1. Are you experiencing pain any place in your mouth at this time? _____ If so, explain: _____
2. Have you been getting regular cleaning during the last 5 years? _____ How often? _____
3. When was your last cleaning? _____
4. Have you had previous periodontal treatment? _____ Periodontists Name/Date _____
5. Do your gums bleed? _____ When you brush/floss? _____ At night in sleep? _____
6. Have you noticed any loose teeth? _____ Shifting teeth? _____
7. Have you noticed any mouth odors or bad tastes? _____ For how long? _____
8. Did any member of your family lose all of their natural teeth? _____ Circle: Mother, Father, Brother, Sister
9. Are your teeth sensitive to heat, cold, or sweets? _____ Which teeth? _____
10. Do meats wedge between your teeth? _____ Which teeth? _____
11. How often do you brush your teeth? _____ Floss Your teeth? _____
12. Do you often have fever blisters on your lips or gums? _____ After dental care? _____
13. Have you had your teeth straightened? _____ Orthodontist/Date Completed? _____
14. Is keeping your teeth important to you? _____ Are you considering any restorative changes? _____
15. Are you satisfied with the appearance of your teeth, what would you desire? _____
16. If you could change the appearance of your teeth, what would you desire? _____
17. Do you smoke? _____ Use any other tobacco products? _____
What and how much? _____
18. Have you been under any unusual stress lately? _____
19. Are you aware of grinding or clenching your teeth during the day? _____ At night? _____ Under Stress? _____
20. Do your jaws click? _____ Pop? _____ Do you have pain in your jaws? _____
21. Do you have headaches regularly? _____ Mornings? _____ Evenings? _____ After eating? _____
22. Do you have any sleep disorders? _____ Snoring problem _____ Sleep Apnea _____
Are you taking medication for this disorder? _____ Have you had surgical treatment for such disorders? _____
Physician/Date of Treatment _____
23. What is your understanding of why you were referred to a periodontist? _____
24. Do you have anxiety about dental treatment? _____ If so, explain _____

MEDICAL HISTORY

1. Have you ever had, or do you now have any of the following:

Personal History		Family History		
Blood Disorders:	_____	Anorexia	_____	
Anemia	_____	Heart Disease:	_____	When? _____
Bleeding problems	_____	Heart Attack	_____	
Clotting problems	_____	Artery Disease	_____	When? _____
Hepatitis (A/B/Other)	_____	Stroke	_____	PreMedicate (Y) (N)
Leukemia	_____	Rheumatic Fever	_____	PreMedicate (Y) (N)
High Blood Pressure	_____	Mitral Valve Prolapse	_____	Type I / Type II
Low Blood Pressure	_____	Diabetes	_____	Type? _____
Ulcer(s)	_____	Skin Diseases	_____	Type? _____
Bowel Trouble	_____	Malignancy	_____	Duration? _____
Kidney Trouble	_____	Radiation Therapy	_____	Where? _____
Bladder Trouble	_____	Artificial Joint Replacement	_____	Medication (Y) (N)
Glaucoma	_____	Thyroid Disease	_____	
Sleep Disorder/Apnea	_____	Lung Trouble	_____	
Psychiatric Treatment	_____	Asthma	_____	
Depression	_____	Chronic Cough	_____	Tested/Treated (Y) (N)
Arthritis	_____	Exposure to Tuberculosis	_____	Tested/Treated (Y) (N)
Bulimia	_____	Exposure to Aids	_____	

COMMENTS: _____

2. Do you have a personal or family history of osteoporosis? _____
3. Have you ever taken cortisone or other steroids? _____ For What/When/Duration? _____
4. Have you ever taken anti-coagulants (blood thinners)? _____ When and for how long? _____
5. Check any drug you have had an adverse reaction to:
- | | | | |
|--------------------|------------------|-------------------------|-------------------|
| ___ Penicillin | ___ Aspirin | ___ Anti-inflammatories | ___ Antibiotics |
| ___ Antihistamines | ___ Barbiturates | ___ Local Anesthetics | ___ Nitrous Oxide |
| ___ Sedatives | ___ Codeine | ___ Demerol | ___ Darvon |
6. Do you bruise easily? _____
7. Have you ever had any procedure/surgery requiring any type sedation? _____ What for? _____
- When? _____ Any Complications? _____
8. Are you on any special diet? To: Lose Weight Lower Cholesterol/Salt Diabetic Food Allergies
9. Have you gained or lost over 10/15 lbs in a short amount of time? _____
10. Do you normally eat meals at regular intervals? _____ Does missing a meal bother you? _____
11. Height _____ Weight _____
12. Do you consider your health to be Good _____ Fair _____ Poor _____
13. Has your general health changed in the last year? _____ Explain _____
14. Please describe any current medical treatment, impending operations, or any other medical or dental procedure that may possibly affect your periodontal care: _____
15. Have you ever fainted? _____ When/Where? _____
16. Please list all prescriptions and non-prescription medications and vitamins you take or intermittent interval: _____
17. Your medical physician (s) _____ Phone _____
18. When was your last physical examination? _____
19. Blood Pressure (will be taken here) Pulse Rate _____
20. **WOMEN:** Are you pregnant? _____ Which month? _____ Do you use Oral Contraceptives? _____

COMMEI _____

PATIENT SIGNATURE AND UPDATES OF HEALTH INFORMATION:

Patient Signature _____ Date _____ Updates _____