

PATIENT HISTORY AND INFORMATION

Name _____ Today's Date _____ Age _____ Birth Date _____ Marital Status _____

Address _____ City _____ Zip _____ Phone _____

Email _____ Cell Phone _____

To confirm appointments, how would you like to be notified? Email Home Phone Call Cell Phone Text

Occupation _____ Employed By _____

Business Address _____ City _____ Zip _____ Phone _____

Name of Spouse _____ Spouse Employed By _____

Occupation _____ Business Address _____ Phone _____

In case of emergency, who may we contact? _____ Phone _____

Name of Dentist _____ City _____ How Long? _____

Name of Physician _____ City _____ Last Physical _____

Referred to this office by _____

What is your reason for seeking periodontal care? _____

Primary Dental Carrier Insurance Co.

Address _____

City, State, Zip _____

Employee _____ Birthdate _____

Group No. _____ Soc. Sec. No. _____

Secondary Dental Carrier Insurance Co.

Address _____

City, State, Zip _____

Employee _____ Birthdate _____

Group No. _____ Soc. Sec. No. _____

MEDICAL HISTORY

Your general health constitutes an important factor, and in combination with other causes, may influence the course of periodontal disease. To assure your health during therapy and to assist in establishing a thorough diagnosis for successful treatment, please complete this confidential form.

Please Circle "yes" or "No" to Each Item

NOTES

1. Do you consider yourself to be in good health? YES NO

2. Are you being treated by a physician now? YES NO
 If so, what for? _____

3. Are you taking any drugs, prescribed medications, or supplements? YES NO
 Please list (include birth control and over counter)

4. Have you been hospitalized or had surgery within the last five years? YES NO
 If yes, what for? _____

5. Indicate which of the following you have had or have at present. Circle "Yes" or "No" to EACH ITEM

Heart Failure.....	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Artificial Joints (hip, knee, etc.).....	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Hepatitis B (Serum).....	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Heart Disease or Attack.....	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Kidney Trouble.....	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Venereal Disease.....	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Angina Pectoris.....	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Ulcers.....	YES <input type="checkbox"/>	NO <input type="checkbox"/>	AIDS.....	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Congenital Heart Disease...	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Diabetes.....	YES <input type="checkbox"/>	NO <input type="checkbox"/>	H.I.V. Positive.....	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Heart Murmur.....	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Thyroid Problems.....	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Cold Sores/Fever Blisters.....	YES <input type="checkbox"/>	NO <input type="checkbox"/>
High Blood Pressure.....	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Glaucoma.....	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Blood Transfusion.....	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Arteriosclerosis.....	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Cosmetic Surgery.....	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Hemophilia.....	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Mitral Valve Prolapse.....	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Emphysema.....	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Anemia.....	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Artificial Heart Valve.....	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Chronic Cough.....	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Sickle Cell Disease.....	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Heart Pacemaker.....	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Tuberculosis.....	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Bruise Easily.....	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Heart Surgery.....	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Asthma.....	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Liver Disease.....	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Rheumatic Fever.....	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Hay Fever.....	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Yellow Jaundice.....	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Arthritis.....	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Allergies or Hives.....	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Epilepsy or Seizures.....	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Rheumatism.....	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Sinus Trouble.....	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Fainting or Dizzy Spells.....	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Cortisone Medicine.....	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Radiation Therapy.....	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Nervousness.....	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Drug Addiction.....	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Chemotherapy.....	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Psychiatric Treatment.....	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Stroke.....	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Hepatitis A (infectious).....	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Developmentally Disabled.....	YES <input type="checkbox"/>	NO <input type="checkbox"/>

6. Are you aware of being allergic to or have you ever reacted adversely to any medication or substance?.....YES NO

If yes, please list: _____

- 7. Do you consider yourself to be under mental or emotional stress? YES NO
- 8. Have you ever had excessive bleeding requiring special treatment? YES NO
- 9. Do you have frequent colds or sinus trouble? YES NO
- 10. Do you have frequent headaches? YES NO
- 11. Do injuries or cuts heal very slowly? YES NO
- 12. Do you have shortness of breath with mild exertion? YES NO
- 13. Do your ankles ever swell? YES NO
- 14. Do you smoke? How many packs per day? _____ YES NO
- 15. Have you ever had x-ray treatment for a tumor? YES NO
- 16. Are you on a special diet or restricted diet now? YES NO
If so, why? _____
- 17. Do you have or have you had any disease, condition or problem not listed? YES NO
If yes, please list: _____
FOR WOMEN ONLY:
- 18. Are you pregnant? If yes, what month? _____ YES NO
- 19. Are you nursing? YES NO
- 20. Are you taking birth control pills? YES NO
- 21. Are you menopausal? YES NO

DENTAL HISTORY

- 1. Are you experiencing discomfort from your mouth at this time? YES NO
- 2. Date of last dental appointment _____
What was done? _____
- 3. How often have you had your teeth cleaned in the past five years?

- 4. Have you had previous periodontal (gum) treatment? YES NO
If so, when? _____
- 5. Do your gums ever bleed when you brush or floss? YES NO
- 6. Have you noticed any loose teeth or change in your bite? YES NO
- 7. Do you have difficulty chewing on either side of your mouth? YES NO
- 8. Are you dissatisfied with the appearance of your teeth? YES NO
- 9. Have you noticed any mouth odors or bad tastes? YES NO
- 10. Do you often develop cold sores or other oral lesions? YES NO
- 11. Are any of your teeth generally sensitive to heat, cold, chewing sweets? YES NO
- 12. Are you aware of grinding or clenching your teeth? YES NO
- 13. When you chew, do you have clicking, popping or pain in your jaw joints? YES NO
- 14. Have you ever been treated for pain in the jaw joints? YES NO
- 15. Have you ever had orthodontic treatment (braces)? YES NO
- 16. How often do you brush your teeth? _____
What type of toothbrush? Hard Medium Soft Electric
- 17. Do you use dental floss or toothpicks between your teeth? YES NO
- 18. Rate the importance you place upon keeping your remaining natural teeth:
1 2 3 4 5
Extremely Important Not Important
- 19. Are you apprehensive about dental treatment YES NO
If so, what is your biggest fear? _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Check here that you have received a copy of This office's Notice of Privacy Practices. It is available to you in office and on our website.

Patient Signature _____ Date _____
(Parent or Guardian)