Ana J. Amaya, D.D.S., M.S., Inc.
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Diplomate of the American Board of Periodontology

Practice Limited to Periodontics and Dental Implants

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

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: _____

NOTES

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)

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