FOR OFFICE USE ONLY

PATIENT INFORMATION

Name _____ Preferred or Nickname _____ Date of Birth _____

Address _____ City _____ State ____ Zip _____

Home Phone _____ Cell _____ Email _____

SS# _____ Drivers Lic# _____

Occupation _____ Work Phone _____ ext. _____

Employer _____ Employer Address _____

Spouse's Name _____ Spouse's Work Phone _____

Employer _____ Employer Address _____

Who referred you to our office? _____

Regular Dentist _____ No. of years _____ Phone _____

IF YOU HAVE DENTAL INSURANCE, PLEASE COMPLETE THE FOLLOWING (IF TWO POLICIES, COMPLETE BOTH PORTIONS).

Insured Person _____ D.O.B. _____ Insured Person _____ D.O.B. _____

SS# _____ Group # _____ SS# _____ Group # _____

Name of Insurance Co. _____ Name of Insurance Co. _____

Ins. Address _____ Phone # _____ Ins. Address _____ Phone # _____

City/State/Zip _____ City/State/Zip _____

MEDICAL HEALTH HISTORY

Periodontal disease is caused by a combination of complex factors and successful treatment depends upon their identification. The following questions are pertinent to the treatment of your periodontal condition. Please answer all questions. Circle yes or no, whichever applies. All answers are confidential.

1. How is your general health? _____
2. Date of last physical examination _____ Height _____ Weight _____
3. Physician's name _____ Specialty _____

   Address and Telephone _____

Circle Yes or No

4. Are you being treated by a ☐ physician, or a ☐ psychiatrist now? ..... Yes or No
5. Have you ever been ☐ seriously ill, or ☐ hospitalized? ..... Yes or No

   If so, explain _____
6. Have you had a transfusion? ..... Yes or No
7. Are you taking any drugs or **medication?** If yes, please check the appropriate box. ..... Yes or No

   ☐ antibiotics ☐ anticoagulants (blood thinners) ☐ antidepressants
   ☐ insulin ☐ blood-pressure medicine ☐ cortisone (steroids)
   ☐ hormones ☐ heart medicine ☐ biophosphonates (Fosamax, Actonel Boniva)
   ☐ aspirin ☐ birth control pills ☐ other _____

   List all prescriptions and medications: _____
8. Have you had radiation treatment or chemotherapy? ..... Yes or No
9. Have you ever had a serious infectious disease? ..... Yes or No

   ☐ Hepatitis ☐ Tuberculosis ☐ Venereal Disease ☐ Herpes ☐ AIDS ☐ Other _____
10. Do you have or have you had any of the following? ..... Yes or No

    ☐ rheumatic heart condition ☐ chest pain on exertion ☐ frequent headaches ☐ asthma ☐ epilepsy
    ☐ heart palpitations ☐ shortness of breath ☐ fainting or dizziness ☐ periods of depression ☐ ulcer
    ☐ high/low blood pressure ☐ heart trouble ☐ tension ☐ cancer or tumor ☐ stroke
    ☐ a heart murmur ☐ heart surgery ☐ liver disorder ☐ diabetes ☐ arthritis
    ☐ heart attack ☐ prolapsed mitral valve ☐ kidney disorder ☐ jaundice ☐ anemia
    ☐ congenital heart lesion ☐ lung problems ☐ thyroid problem ☐ glaucoma
    ☐ other _____
11. Have you had abnormal bleeding associated with extractions, surgery, or menstruation? ..... Yes or No

PLEASE COMPLETE REVERSE SIDE

12. Do you have a cardiac pacemaker, prosthetic heart valve or prosthetic joint? ..... Yes or No
    What do you have? _____
13. Are you **allergic** or have you experienced an unusual reaction to any drugs? ..... Yes or No
    - ☐ dental anesthetic
    - ☐ codeine
    - ☐ aspirin
    - ☐ latex
    - ☐ penicillin
    - ☐ erythromycin
    - ☐ tetracycline
    - ☐ sulfa
    - ☐ Valium
    - ☐ Demerol
    - ☐ barbituates or sedatives
    - ☐ other _____
14. Do you use tobacco? ..... Yes or No
    How much? _____
15. Is there a tendency towards any illness in your family? ..... Yes or No
    - ☐ diabetes
    - ☐ heart trouble
    - ☐ other _____
16. Do you have any disease, condition, or problem not listed that I should know about? ..... Yes or No
    _____
17. Women: Are you pregnant? ..... Yes or No

DENTAL HEALTH HISTORY

Circle Yes or No

1. Why are you visiting our office? _____
   _____
   _____
2. Has your dental care been:
   ☐ regular (yearly) ☐ intermittent (when necessary) ☐ infrequent (when in pain)
3. How many cleaning appointment have you had in the last 10 years?
4. Have you ever had Periodontal care? ..... Yes or No When _____
   Orthodontic care? ..... Yes or No When _____
5. Are you dissatisfied with the appearance of your teeth? ..... Yes or No
6. Have you ever experienced any of the following? ..... Yes or No
   - ☐ bleeding gums
   - ☐ swelling of gums
   - ☐ pain or soreness in gums
   - ☐ receding gums
   - ☐ pus around the teeth
   - ☐ loose teeth
   - ☐ spaces between teeth
   - ☐ drifting of teeth
   - ☐ foul odor
   - ☐ bad breath or bad taste
   - ☐ food packing between teeth
   - ☐ high or rough fillings
7. Are your teeth sensitive? ..... Yes or No
   If so, to what? _____
8. Do you grind or clench your teeth? ..... Yes or No
9. Have you ever had an injury to your face, neck, or jaws? ..... Yes or No
10. Do you suffer from pain in the face, neck, or jaws? ..... Yes or No
11. Are you having pain in your mouth now? ..... Yes or No
12. These statements are true and complete to the best of my knowledge ..... Yes or No

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect April 14, 2003, and will remain in effect until we replace it.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of the notice, please request a copy at your first appointment.

_____ _____

Signature of Patient Date Signature of Doctor Date

Please be advised that 24 hours' notice of inability to keep your appointment is expected. Otherwise, reasonable fees for time lost will be charged. In addition, we advise all patients to visit a general dentist for decay examinations annually.

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History: