**FOR OFFICE USE ONLY**

## PATIENT INFORMATION

Date _____ Date of Birth _____

Patient _____ Soc. Sec. No. _____

Home Address _____ Home Phone _____ Cell _____

City _____ State _____ Zip _____ Email _____

Patient's Occupation _____ Driver's Lic _____

Patient's Employer _____ Address _____ Phone _____

Spouse's Name _____ Spouse's Occupation _____

Who referred you to our office? _____

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

Primary Subscriber _____ D.O.B. _____
Employer of Above _____ Phone _____
Address _____ Group # _____
Name of Insurance Co. _____
Claims Address _____ S.S. # _____

Primary Subscriber _____ D.O.B. _____
Employer of Above _____ Phone _____
Address _____ Group # _____
Name of Insurance Co. _____
Claims Address _____ S.S. # _____

To avoid misunderstanding regarding dental insurance, we wish that our patients know that ALL PROFESSIONAL SERVICES RENDERED are CHARGED DIRECTLY TO THE PATIENT and that the PATIENTS ARE PERSONALLY RESPONSIBLE FOR PAYMENT OF FEES. We will prepare the necessary forms or reports to help you obtain your benefits from insurance companies. We do not render our services on the basis that insurance companies will pay our fees.

### 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.

**If you have a heart murmer, you may need to be pre-medicated for all treatment, including the periodontal examination.**

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

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. Are you taking any drugs or medication? If yes, please check the apropriate box ..... Yes or No

| | | |
|---|---|---|
| ☐ antibiotics | ☐ anticoagulants (blood thinners) | ☐ tranquilizers |
| ☐ insulin | ☐ blood pressure medicine | ☐ cortisone (steroids) |
| ☐ hormones | ☐ heart medicine | ☐ Fosamax, Actonel, Boniva |
| ☐ aspirin (Please note: Chronic aspirin consumption can cause bleeding problems.) | ☐ birth control pills | ☐ other _____ |

7. Have you ever had a serious infectious disease? ..... Yes or No

☐ Hepatitis ☐ AIDS ☐ Tuberculosis ☐ Syphilis ☐ Other _____

**PLEASE COMPLETE REVERSE SIDE**

8. Do you have or have you had any of the following? ..... Yes or No

| | | | | |
|---|---|---|---|---|
| ☐ heart attack | ☐ chest pains on exertion | ☐ frequent headaches | ☐ x-ray therapy | ☐ epilepsy |
| ☐ heart palpitations | ☐ low blood pressure | ☐ fainting or dizziness | ☐ periods of depression | ☐ ulcer |
| ☐ high blood pressure | ☐ shortness of breath | ☐ tension | ☐ cough | ☐ stroke |
| ☐ a heart murmur* | ☐ heart trouble | ☐ liver disorder | ☐ cancer or tumor | ☐ arthritis |
| ☐ osteoporosis | ☐ kidney disorder | ☐ diabetes | ☐ anemia | ☐ other _____ |
| ☐ mitral valve prolapse | ☐ lung problems | ☐ jaundice | ☐ glaucoma | |

9. Do you have any implants such as a heart valve or hip replacement?* ..... Yes or No

What do you have? _____

* If you have these conditions, please call our office to discuss possible premedication prior to your initial appointment.

10. Have you had abnormal bleeding associated with extractions, surgery, or menstruation? ..... Yes or No

11. Are you allergic or have you experienced an unusual reaction to any drugs? ..... Yes or No

| | | |
|---|---|---|
| ☐ dental anesthetic | ☐ penicillin | ☐ barbiturates or sedatives |
| ☐ codeine | ☐ sulfa drugs | ☐ other _____ |
| ☐ aspirin | ☐ tetracycline | |
| ☐ erythromycin | ☐ other antibiotics | |

12. Do you have any allergic condition? ..... Yes or No

| | | |
|---|---|---|
| ☐ asthma | ☐ skin rashes, hives, hay fever | ☐ sinus problems |

13. Is there a tendency towards any illness in your family ..... Yes or No

| | | |
|---|---|---|
| ☐ diabetes | ☐ heart trouble | ☐ other _____ |

14. Do you have any disease condition, or problem not listed that I should know about? ..... Yes or No

_____

15. Women: Are you pregnant? ..... Yes or No

16. Do you smoke? _____ What _____ How many _____

## DENTAL HEALTH HISTORY

**Circle Yes or No**

1. Who is your regular dentist? _____

2. Has your dental care been:

☐ Regular (yearly) ☐ Intermittent (when necessary) ☐ Infrequent (when needed) Approx. date of last visit _____

3. Have you ever had periodontal care? ..... Yes or No When? _____ Orthodontic care? Yes or No When _____

4. Would you be very disturbed if you had to lose your teeth and wear false teeth? ..... Yes or No

5. Are you dissatisfied with the appearance of your teeth? ..... Yes or No

6. Have you experienced any of the following? ..... Yes or No

| | | |
|---|---|---|
| ☐ bleeding gums | ☐ pus around teeth | ☐ foul odor |
| ☐ swelling gums | ☐ loose teeth | ☐ bad breath or bad taste |
| ☐ pain or soreness | ☐ spaces between teeth | ☐ food packing between teeth |
| ☐ receding gums | ☐ drifting of teeth | ☐ high or rough fillings |

7. Is there sensitivity in your teeth? ..... Yes or No

| | | |
|---|---|---|
| ☐ hot | ☐ sweet | ☐ tooth brushing |
| ☐ cold | ☐ biting | ☐ pressure |

8. Have you ever had an injury to your face, neck, or jaws? ..... Yes or No

9. Do you suffer from pain or have symptoms in the face, neck, or jaw? ..... Yes or No

Remarks: _____

_____

_____

_____

These statements are true and complete to the best of my knowledge. I hereby authorize the undersigned provider to release any information aquired in the course of my treatment in accordance with HIPPA.

_____ _____

Signature of Patient, Parent or Guardian Date

**Please be advised that 24 hour notice of inability to keep your appointment is expected, otherwise a reasonable fee for time loss will be charged. In addition, we advise all patients to visit a general dentist for decay examination annually.**