NEW PATIENT INFORMATION **Please print.** **Date**__________

Please answer the following completely. Your answers are for our records and they are considered confidential.

Name __________ (LAST / FIRST / MIDDLE) Phone (____)________ (HOME) | (____)________ (BUS. / EXT.)

Address __________ (NUMBER / STREET / CITY / STATE / ZIP)

Birthdate __________ (MO. / DAY / YEAR) Social Security No. ____–____–____

Occupation __________ Employer __________ (NAME / ADDRESS)

Spouse's Name __________ Spouse's Employer __________ (NAME / ADDRESS / PHONE)

Spouse's Social Security No. ____–____–____ Spouse's Birthdate __________ (MO. / DAY / YEAR)

INSURANCE: Dental Insurance-Primary __________ (NAME OF COMPANY / GROUP NUMBER)

__________ (NAME OF POLICY HOLDER / POLICY HOLDER SS#)

Dental Insurance - Secondary __________ (NAME OF COMPANY / GROUP NUMBER)

__________ (NAME OF POLICY HOLDER / POLICY HOLDER SS#)

What is the name of your general dentist? __________ Office telephone number (____) ________

How many times have you had your teeth cleaned in the last 5 years?________ Last cleaning? ________

Are you experiencing pain from your mouth at this time? ________

Do your gums bleed? ________ When you brush? ________ At night in sleep? ________

Have you noticed any loose teeth? ________ Shifting teeth? ________

Have you noticed any mouth odors or bad tastes? ________ For how long? ________

Are your teeth sensitive to sweets? ________ hot? ________ cold? ________

Are you aware of grinding your teeth at night in your sleep? ________

Do you have clicking? ________ Popping? ________ Pain? ________ in the jaw joints?

Do you clinch your teeth together? ________

Do you have headaches regularly? ________ Mornings? ________ Evenings? ________ After eating? ________

How often do you brush your teeth? ________ Floss your teeth? ________

What kind of brush do you use - Hard? ________ Medium? ________ Soft? ________

Have you ever had trench mouth? ________ If so, when? ________

Do you often have fever blisters on your lips?________ After dental care? ________

Have you been under more stress than average lately?________

Do you smoke? ________ What and how much?________

Have you had your teeth straightened? ________ When? ________

Are you satisfied with the appearance of your teeth? ________

Did either your mother, father, brother, or sister lose all of their natural teeth? ____________ if yes, who? ____________

Have you had previous periodontal treatments? ____________ When? ____________

Have you ever had an extremely frightening experience with dentistry? ____________ Explain ____________

Are you fearful of undergoing periodontal therapy? ____________ Why? ____________

Have you ever fainted? ____________ In a dental office? ____________

Have we treated any of your family or friends? ____________ Who? ____________

Do you consider your physical health to be good? ____________ Fair? ____________ Poor? ____________

Are you on a diet at this time? ____________ Why? ____________

Have you gained? ____________ or lost? ____________ weight recently. How much? ____________

Are you taking any medications, drugs, or pills regularly? ____________ If so, what? ____________

Have you ever taken cortisone (steroids)? ____________ When and for how long? ____________

Have you taken anti-coagulants (blood thinner)? ____________ When and for how long? ____________ For what purpose? ____________

Do you use controlled substances? ____________

Have you been told you must be premedicated with antibiotics prior to receiving dental treatment? ____________

Do you tire easily? ____________ When? ____________

Do you bruise easily? ____________

Have you had major surgery? ____________ What/When ? ____________ Any complications? ____________

Please describe any current medical treatment, impending operations, or any other medical or dental information that may possibly affect your periodontal care: ____________

Have you ever had, or do you now have, any of the following?

- ☐ AIDS/HIV Positive
- ☐ Alzheimer's Disease
- ☐ Anemia
- ☐ Arthritis/Gout
- ☐ Artificial Heart Valve
- ☐ Artifical Joint
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chest Pains
- ☐ Convulsions
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Emphysema
- ☐ Epilepsy or Seizures
- ☐ Excessive Bleeding
- ☐ Excessive Thirst
- ☐ Fainting Spells/Dizziness
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Heart Attack/Failure
- ☐ Heart Murmur
- ☐ Heart Pace Maker
- ☐ Heart Trouble/Disease
- ☐ Hepatitis A
- ☐ Hepatitis B or C
- ☐ High Blood Pressure
- ☐ Hypoglycemia
- ☐ Kidney Problems
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lung Disease
- ☐ Mitral Valve Prolapse
- ☐ Pain in Jaw Joints
- ☐ Psychiatric Care
- ☐ Radiation Treatments
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shingles
- ☐ Sinus Trouble
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Tumors or Growths
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Other ____________

Circle, or not, the drug(s) you have an allergy to: PENICILLIN ASPIRIN CODEINE LATEX DEMEROL

ANTIHISTAMINES LOCAL ANESTHETICS ANTIBIOTICS OTHER ____________

Are you being treated by a physician at this time? ____________ For what? ____________

What is the name of your physician? ____________ Office telephone number (______) ____________

Women: Are you pregnant? ____________ Which month? ____________

Have you reached menopause? ____________ Are you taking hormones? ____________ Oral contraceptives? ____________

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SIGNATURE OF PATIENT DATE

(If Patient is under eighteen years of ago, we much have Parent's or Guardian's signature to authorize treatment.)

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SIGNATURE OF PERIODONTIST DATE