

PATIENT HISTORY AND INFORMATION

Name _____ Today's Date _____ Age _____ Birth Date _____ Marital Status _____
 Address _____ City _____ Zip _____ Phone _____
 Occupation _____ Employed By _____
 Business Address _____ City _____ Zip _____ Phone _____
 Name of Spouse _____ Spouse Employed By _____
 Occupation _____ Business Address _____ 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? _____

Do you have dental insurance? Yes No

Primary Carrier Insurance Co.

Secondary Carrier Insurance Co.

_____ Address _____ City, State, Zip _____ Employee _____ Birthdate _____ Group No. _____ Soc. Sec. No. _____	_____ Address _____ City, State, Zip _____ Employee _____ Birthdate _____ Group No. _____ Soc. Sec. No. _____
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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? If so, what for? _____	YES	NO	
3. Are you taking any drugs or prescribed medication? Please list (Include Birth Control) _____	YES	NO	
4. Have you been hospitalized or had surgery within the last five years? If yes, what for? _____	YES	NO	
5. Indicate which of the following you have had or have at present. Circle "Yes" or "No" 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: _____			

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|--|-----|----|
| 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?
Why? _____ | YES | NO |
| 17. Do you have or have you had any disease, condition or problem not listed?
If yes, please list: _____
_____ | YES | NO |
- 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 |

NOTES

DENTAL HISTORY

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|---|-----|----|
| 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? _____
When was your most recent cleaning? _____ | | |
| 4. Have you had previous periodontal (gum) treatment?
If so, when? _____ | YES | NO |
| 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 or 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? <input type="checkbox"/> Hard <input type="checkbox"/> Medium <input type="checkbox"/> Soft | | |
| 17. Do you use dental floss or toothpicks between your teeth?
How often? _____ | 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?
If so, what is your biggest fear? _____ | YES | NO |

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.

Patient Signature _____ Date _____