



### Patient Information

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Gender M F Date of Birth (mo/day/year) \_\_\_\_\_ Social Security # \_\_\_\_\_

Email \_\_\_\_\_ Home Phone \_\_\_\_\_ Work/Cell \_\_\_\_\_

Preferred Method of Contact ( \_\_\_\_\_ )

Address \_\_\_\_\_ Apartment # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

### Responsible Party Information (if patient is under age 18)

Name \_\_\_\_\_

Gender M F Date of Birth (mo/day/year) \_\_\_\_\_ Social Security # \_\_\_\_\_

Phone (Home) \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employer Name \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

### Dental Insurance Information

#### PRIMARY PLAN

#### SECONDARY

Carrier \_\_\_\_\_ Carrier phone \_\_\_\_\_ Carrier \_\_\_\_\_ Carrier phone \_\_\_\_\_

Carrier address \_\_\_\_\_ Carrier address \_\_\_\_\_

Subscriber \_\_\_\_\_ Employer \_\_\_\_\_ Subscriber \_\_\_\_\_ Employer \_\_\_\_\_

Soc Sec # \_\_\_\_\_ Birth date \_\_\_\_\_ Group # \_\_\_\_\_ Soc Sec # \_\_\_\_\_ Birth date \_\_\_\_\_ Group # \_\_\_\_\_

### Important Dental Information

*Although some of the following questions may seem unrelated to your teeth, they are associated with proper management of your oral health and are confidential.*

Name of General Dentist \_\_\_\_\_ City \_\_\_\_\_ Date of last cleaning \_\_\_\_\_

Have you had previous periodontal treatment?  Yes  No Are you having any dental pain or discomfort?  Yes  No

Are you apprehensive about dental work?  Yes  No If yes, please explain \_\_\_\_\_

Do you have any suggestions on how we can make your periodontal treatment less stressful and more comfortable for you?  
\_\_\_\_\_

Have you been advised by your physician to pre-medicate with antibiotics prior to dental treatments?  Yes  No

If yes, which medication? \_\_\_\_\_ Why prescribed? \_\_\_\_\_

### Check all that apply

- Bad Breath
- Bad Taste
- Bleeding Gums
- Clenching
- Difficulty Chewing
- Frequent Headaches
- Painful Gums
- Receding Gums
- Sensitive Teeth
- TMJ
- Grinding
- Dry Mouth

### Health Information

Name of Primary Care Physician \_\_\_\_\_ Phone \_\_\_\_\_

Date of last physical exam \_\_\_\_\_ Results \_\_\_\_\_

Have you been admitted to a hospital or needed emergency care during the past two years?  Yes  No

If yes, please explain: \_\_\_\_\_

Please list any medications, including non-prescription drugs, taken on a regular basis

\_\_\_\_\_

Have you had surgery or X-Ray treatment for a tumor, growth or other conditions of your head, mouth, or lips?  Yes  No

Are you currently or have you taken?  Actonel  Aridia  Boniva  Fosamax  Zometa

Have you ever had bleeding or difficulty with blood clotting?  Yes  No

Are you taking blood thinners (i.e. Coumadin)?  Yes  No If Yes, last INR Level (\_\_\_\_\_) Date: \_\_\_\_\_

Do you take Aspirin?  Yes  No

Do you smoke?  Yes  No If yes, for how long \_\_\_\_\_ (packs per day \_\_\_\_\_)

Do you drink alcohol?  Yes  No If yes, drinks per month \_\_\_\_\_, week \_\_\_\_\_, day \_\_\_\_\_

Do you use recreational drugs?  Yes  No If yes, for how long \_\_\_\_\_) which drug: \_\_\_\_\_

**For Women Only:** Some medications used in dentistry will cross the placental and breast milk barrier, and might affect the unborn fetus. Antibiotic use may reduce the effectiveness of birth control pills, and alternate methods are recommended if taking them.

- Have you reached menopause?  Yes  No
- Are you using hormone replacement therapy (HRT)?  Yes  No
- Do you use birth control pills, injection  Yes  No (which one) \_\_\_\_\_
- Are you pregnant at the present time?  Yes / Due Date \_\_\_\_\_  No  Possibly
- Are you breastfeeding at the present time?  Yes  No

### Have you ever had any of the following? Please check those that apply

- AIDS
- Allergies \_\_\_\_\_
- Artificial Heart Valve
- Anemia
- Arthritis
- Artificial Joints
- Month: \_\_\_ Year: \_\_\_\_\_
- Asthma
- Bacterial Endocarditis
- Cancer
- Diabetes
- Type \_\_\_\_\_
- Last A1C Level \_\_\_\_\_
- Date of Test: (\_\_\_\_\_)
- Dizziness
- Epilepsy
- Excessive Bleeding
- Fainting
- Glaucoma
- Hay Fever
- Head Injuries
- Heart Disease
- Heart Murmur
- Hepatitis Type \_\_\_\_\_
- Herpes
- High Blood Pressure
- Jaundice
- Kidney Disease
- Liver Disease
- Mental Disorders
- Nervous Disorders
- Organ Transplant
- Pacemaker
- Prostate Disorder
- Prosthetic Implant
- Radiation Treatment
- Respiratory Problems
- Rheumatic Fever
- Rheumatism
- Seizures/Convulsions
- Sinus Problems
- Sleep Apnea
- Stomach Problems
- Stroke
- Thyroid Disease
- Tuberculosis
- Tumors
- Ulcers
- Venereal Disease
- C-Diff
- COPD
- OTHER \_\_\_\_\_

### Have you ever had an adverse reaction or allergy to any of the following

- Aspirin
- Anti-Inflammatory Medication
- Codeine Allergy
- Dental Anesthetics
- Latex Materials
- Penicillin Allergy
- Percodan Allergy
- Valium/Tranquilizers
- Other

Type of reaction to above med \_\_\_\_\_ Are there medications that you cannot take \_\_\_\_\_

To the best of my knowledge, the information provided is true and correct. I understand that all appointments require 48 business hour cancellation notice.

Signature of patient, parent or guardian \_\_\_\_\_

Date \_\_\_\_\_