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PERIODONTAL MICROSURGERY
DENTAL IMPLANTOLOGY

Kenneth Abe, D.D.S.

Periodontics, Microsurgery, Dental Implants

Patient Information Form

Legal Name:	**Referred By:**
Address:	**Home Phone:** **Work Phone:**
Your Date of Birth:	**Employer:**
Spouse/Parent's Name:	**Spouse/Parent's Birthdate:**
Emergency Contact's Name:	**Emerg. Contact Phone:**
General Dentist's Name:	**How long seen?**
Physician's Name:	**Physician's Telephone:**
Your Preferred Pharmacy:	**Your Mobile Telephone:**
Primary Dental Insur.: **Through which employer?**	**Subscriber Name:** **ID/Social Security#**
Secondary Dental Insur.: **Through which employer?**	**Subscriber Name:** **ID/Social Security#**
Present Dental Complaints:	
How would you like us to help you? **Do you want to save your teeth?** ☐ **YES** ☐ **NO**	
How do you prefer to be addressed?	

HEALTH HISTORY

For your welfare and our efficiency of diagnosis and treatment, please fill out this form COMPLETELY. Thank you.

1.	Are you under a physician's care for anything? _____	☐ Yes ☐ No	If Yes to 1,2,3 Explain:
2.	Have you been under a physician's care in the past 5 years?	☐ Yes ☐ No	
3.	Have you ever been hospitalized or had any operation?	☐ Yes ☐ No	
	Please explain:_____		
4.	Have you ever had an unusual or unpleasant experience in a dental office?	☐ Yes ☐ No	
	Please explain: _____		
	WOMEN QUESTIONS 5 - 8		
5.	Are you pregnant? If so, what month?	☐ Yes ☐ No	
6.	Are you nursing?	☐ Yes ☐ No	
7.	Have you had any complications with past pregnancies?	☐ Yes ☐ No	
8.	Are you presently in menopause or post-menopause?	☐ Yes ☐ No	
9.	Do you now have or have you ever had any of the following conditions?		
	a. Heart Disease	☐ Yes ☐ No	
	b. Glaucoma	☐ Yes ☐ No	
	c. Shortness of breath with limited activity or while resting	☐ Yes ☐ No	
	d. Frequently swollen ankles	☐ Yes ☐ No	
	e. Chest pain or angina pectoris	☐ Yes ☐ No	
	f. Heart attack:	☑ Yes ☐ No	
	g. Rheumatic Fever or Rheumatic Heart Disease	Yes ☐ No	
	h. Heart Murmur	☐ Yes ☐ No	
	i. Heart Defect from birth	☐ Yes ☐ No	
	j. High or low blood pressure	☐ Yes ☐ No	
	k. Stroke	Yes ☐ No	
	l. Fainting spell, convulsions or Epilepsy	☐ Yes ☐ No	
	m. Nervous breakdown, emotional problems or psychiatric care	Yes ☐ No	
	n. Lung disease (Tuberculosis, Asthma, Emphysema or other)	☐ Yes ☐ No	
	o. Liver Disease (Hepatitis, Jaundice, Cirrhosis or other)	☐ Yes ☐ No	
	p. Nasal Polyps (allergic to Tartrason Dye)	☑ Yes ☐ No	
	q. Kidney Disease	☐ Yes ☐ No	
	r. Diabetes	☑ Yes ☐ No	
	s. Family member with Diabetes-whom?_____	☐ Yes ☐ No	
	t. Frequent urination	☑ Yes ☐ No	
	u. Often thirsty	☐ Yes ☐ No	
	v. Prolonged bleeding following injury or surgery or bleeding problems	☐ Yes ☐ No	
	w. Blood disorder (Anemia or other)	☐ Yes ☐ No	
	x. Easily bruised	☐ Yes ☐ No	
	y. Slow healing of cuts in skin	☐ Yes ☐ No	
	z. Arthritis	☐ Yes ☐ No	
	aa. X-Ray Treatments or Radiation Therapy	☐ Yes ☐ No	
	bb. Cancer or other tumor	☐ Yes ☐ No	
	cc. Herpes	☐ Yes ☐ No	
	dd. Compromised Immunity (A.I.D.S./HIV)	☐ Yes ☐ No	
	ee. Thyroid problems	☐ Yes ☐ No	

(Continue)

ff. Limitations in activity or diet ☐ Yes ☐ No
please explain _____
gg. Do you have a pacemaker? ☐ Yes ☐ No

10. Have you ever had any sinus problems? ☐ Yes ☐ No
Please explain:_____

11. Have you become sick from, shown an allergy to or been told not to take any of the following medications?
a. Penicillin or other antibiotics - list:_____ ☐ Yes ☐ No
b. Aspirin, Codeine or other pain medications -list: _____ ☐ Yes ☐ No
c. Novocaine, Xylocaine or other anesthetics - list _____ ☐ Yes ☐ No
d. Other medications-List_____
e. Have you had a recent weight change? Increase or decrease? ☐ Yes ☐ No
f. Have you taken Phen Fen or Redux? ☐ Yes ☐ No
g. Do you often feel exhausted or fatigued? ☐ Yes ☐ No

12. Do you smoke or use tobacco? How much per day?_____ ☐ Yes ☐ No
13. Is there anything of importance in your medical history that has not been asked? ☐ Yes ☐ No
Explain:_____
14. Do you have an allergy to Latex? ☐ Yes ☐ No
15. Date of last medical exam? _____
16. Are you taking any medications or drugs at present? ☐ Yes ☐ No
Explain: _____
17. Are you taking any vitamins, herbs or nutritional/dietary supplements? ☐ Yes ☐ No
18. Explain: _____
19. Are you taking daily aspirin? ☐ No ☐ Yes. did a physician instruct you to do so? ☐ Yes ☐ No

Dental History

1. Have you ever had trench mouth? ☐ Yes ☐ No
2. Have you ever had treatment for periodontal disease? ☐ Yes ☐ No
Explain:_____
3. Have you ever seen another periodontist? ☐ Yes ☐ No
Whom?_____
4. Have you ever experienced any of the following:

a.. Bleeding gums:	☐ Yes ☐ No	g. Spaces between teeth:	☐ Yes ☐ No
b. Swollen gums:	☐ Yes ☐ No	h. Drifting of teeth:	☐ Yes ☐ No
c. Pain/Soreness in gums:	☐ Yes ☐ No	i. Foul odor:	☐ Yes ☐ No
d. Receding gums:	☐ Yes ☐ No	j. bad breath or bad taste:	☐ Yes ☐ No
e. Pus around teeth:	☐ Yes ☐ No	k. food packing between teeth	☐ Yes ☐ No
f. Loose teeth:	☐ Yes ☐ No	l. sensitivity in teeth:	☐ Yes ☐ No

5. Do you grind your teeth during the day or night? ☐ Yes ☐ No
6. Do you have pain elsewhere in your face or jaws? ☐ Yes ☐ No
7. Have you ever been informed that you have a gum condition? ☐ Yes ☐ No
When?_____ By whom?_____
8. Have you ever had your teeth straightened? ☐ Yes ☐ No
9. How many times per day do you brush your teeth? _____
10. Do you use dental floss, toothpicks, water irrigation or other similar devices ☐ Yes ☐ No
If Yes, how often?_____
11. How often do you have your teeth professionally cleaned?_____
12. When was your last professional cleaning?_____
13. Are you taking Fosomax or any other bone building medication?_____ If so, which one?_____ For how long?_____

Office Policies

APPOINTMENTS: So that we may maintain the operation of our office on sound principles and to assure you and other patients of uninterrupted treatment, it is necessary for all patients to accept and adhere to a definite arrangement of appointments. Once you have made an appointment, that time has been reserved for you. THEREFORE, **WE KINDLY REQUEST THAT AT LEAST 48 HOURS/2 BUSINESS DAYS BE GIVEN FOR PERIO. MAINTENANCE THERAPY OR 3 BUSINESS DAYS FOR SURGERY IF CANCELLATION IS ABSOLUTELY NECESSARY. LATE CANCELLATION OR FAILED APPOINTMENTS ARE SUBJECT TO A CHARGE.**

In order to prevent misunderstanding about dental, medical or any other insurance, we wish our patients to know that ALL SERVICES FURNISHED TO PATIENTS BY OUR OFFICE ARE CHARGED DIRECTLY TO YOU, THE PATIENT (OR THE PATIENT'S LEGAL GUARDIAN), AND THAT PATIENTS (OR THEIR LEGAL GUARDIANS) ARE PERSONALLY RESPONSIBLE FOR PAYMENTS OF BILLS. We will collect payment at each visit for services provided that day, unless otherwise arranged in advance. We will prepare necessary reports to help collect your benefits from insurance companies. However, it must be understood that we do not render our services on the basis of insurance companies paying our fees. Each fee is charged to the patient. By signing below, I agree to be responsible to pay for services rendered independent of insurance coverage.

CONSENT TO RELEASE OF DENTAL AND MEDICAL RECORDS: By signing below, I consent to release of any dental or medical records deemed necessary by Dr. Abe , to and from Dr. Abe and other entities to obtain information on medical conditions or assist in your medical-dental treatment or reimbursement for said treatment..

Notice of Privacy Practices: By signing below, I declare that I have received or have been offered a copy of Dr. Abe's " "Notice of Privacy Practices."

SIGNATURE:_____ **DATE:**_____

Responsible Party (if under 18 Legal Guardian):

NAME: (Print)_____