



**Samir F. Zakaria, D.D.S., M.S.D**  
**Periodontics & Dental Implants**  
*Diplomate, American Board of Periodontology*

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_  
(Last) (First) (MI)

- Male  
 Female

Married Single Child Other

Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Driver License Number: \_\_\_\_\_

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

Best Time to call: \_\_\_\_\_ Email Address: \_\_\_\_\_

Address: \_\_\_\_\_

(Street) (Apartment #)

(City) (State) (Zip Code)

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_

(Street) (City) (State) (Zip Code)

Employer Phone Number: \_\_\_\_\_

### **Insurance Information**

Do you have Dental Insurance?

- Yes  
 No

If So,

Name of Dental Insurance: \_\_\_\_\_

Name of Subscriber: \_\_\_\_\_

Subscriber's Social Security Number: \_\_\_\_\_

Subscriber's Date of Birth: \_\_\_\_\_

Relationship To Patient: \_\_\_\_\_

Place of Employment: \_\_\_\_\_

Do you have any other Dental Insurance?

- Yes  
 No

If so,

Name of Dental Insurance: \_\_\_\_\_

Name of Subscriber: \_\_\_\_\_

Subscriber's Social Security Number: \_\_\_\_\_

Subscriber's Date of Birth: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Place of Employment: \_\_\_\_\_

### **Dental & Medical History**

1. When did you last have your teeth cleaned? \_\_\_\_\_
2. Do you ever Wake up from sleep short of breath, or sleep on more than two pillows? Y N
3. When were you first made aware that you had a periodontal (gum) Problem? \_\_\_\_\_
4. Have you ever had periodontal (gum) Treatment? Y N
5. If yes when? \_\_\_\_\_
6. Have you noticed any bad odors or tastes from your mouth? Y N
7. How often do you brush your teeth? \_\_\_\_\_ Times a day.

8. Does your Jaw Click when you chew? Y N  
 9. Is it difficult to open your mouth as wide as you would like to? Y N  
 10. Do you clench, grit or grind your teeth in the daytime or while you are sleeping? Y N  
 11. Do you smoke?  
 If so what? \_\_\_\_\_ How Long? \_\_\_\_\_

12. Have you been to see a physician within the past two years? Y N  
 If yes, for what problem? \_\_\_\_\_

13. Please give the name and address of you regular physician:

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14. Have you been a Patient in the hospital in the past two years? Y N

15. CIRCLE any of the following, which you have had or have at the present time:

HEART DISEASE	CHRONIC COUGH	PERSISTANT DIARRHEA
ANGINA	TUBERCULOSIS	HEPATITIS
RHEUMATIC FEVER	ASTHMA	LIVER DISEASE
HEART MURMUR	HAY FEVER	BLOOD TRANSFUSION
ARTIFICIAL HEART VALVE	ALLERGIES	HEMOPHILIA
HEART PACEMAKER	DIABETES	VENEREAL DISEASE
HEART SURGERY	THYROID DISEASE	ANEMIA
ARTIFICIAL JOINT	RADIATION TREATMENT	GENITAL HERPES
HIGH BLOOD PRESSURE	CHEMOTHERAPY	COLD SORES
STROKE	CANCER	EPILEPSY OR SEIZURES
KIDNEY TROUBLE	CORTISONE MEDICINE	NERVOUSNESS
ULCERS	ARTHRITIS	FAINTING OR DIZZY SPELLS
EMPHYSEMA	GLAUCOMA	PSYCHIATRIC TREATMENT
AIDS	SICKLE CELL DISEASE	NONE

16. Is there any history of diabetes in your family? Y N

17. Have you ever had any operations or surgery? Y N  
 If yes, for what purpose? \_\_\_\_\_

18. Have you ever had any excessive bleeding requiring special treatment? Y N

19. Are you taking any medicine, drugs or pills of any kind? Y N  
 If yes, what kind? \_\_\_\_\_

20. Do you have any allergies to drugs or medicine? Y N  
 If yes, to what and how do you react? \_\_\_\_\_

21. Have you ever had an unusual reaction to dental anesthetic? Y N

22. When you walk upstairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired? Y N

23. Do your ankles swell during the day? Y N

24. Do you sleep on more than two pillows? Y N

25. Do you wake up from sleep short of breath? Y N

26. Have you unintentionally lost or gained more than 10 pounds in the last year? Y N

27. Are you on a special diet? Y N

28. Has your medical doctor ever said you have cancer or tumor? Y N

29. Have you ever been premedicated with an antibiotic before your dental appointment? Y N

30. WOMEN:

- Are you pregnant now? Y N

- Are you practicing birth control? Y N

- Do you anticipate becoming pregnant? Y N

- Have you undergone or are you undergoing menopause? Y N

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Name

Signature

Date