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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: ____

<u>Dental & Medical History</u>

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:
____
____

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
ARTIFICAL 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