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BOARD CERTIFIED • AMERICAN BOARD OF PERIODONTOLOGY

## PATIENT INFORMATION

**PATIENT'S NAME** ______________________________ **TODAY'S DATE** __________

Home Address: ______________________________ City: __________ Zip: __________

Email Address: ______________________________ Res. Tel.: (___) __________

Social Security No.: __________ Date of Birth: __________ Age: _____ Cell Phone: (___) __________

Marital Status: Single Married Separated Divorced Widowed (Circle One)

Occupation: ______________________________ Employer's Name: __________

Business Address: __________ City: __________ Zip: __________ Bus. Tel.: (___) __________

Spouse's Name: __________ Social Security No.: __________ Bus. Tel.: (___) __________

Spouse's Occupation: __________ Spouse's Employer: __________

PERSON TO CONTACT IN AN EMERGENCY: ______________________________

Relationship: ______________________________

Res. Phone: (___) __________ Bus. Phone: (___) __________

PARTY RESPONSIBLE FOR PAYMENT OF ACCOUNT: ______________________________

Res. Phone: (___) __________ Bus. Phone: (___) __________

IF YOU HAVE DENTAL INSURANCE, PLEASE COMPLETE THE FOLLOWING:

| | PRIMARY CARRIER | SECONDARY CARRIER |
|---|---|---|
| **Insured's Name:** | __________ | __________ |
| **Insurance Co. Name:** | __________ | __________ |
| **Policy No.:** | __________ | __________ |
| **Insurance Co. Address:** | __________ | __________ |
| **Phone No.:** | __________ | __________ |

**Whom may we thank for referring you?** ______________________________

**Reason for this visit:** ______________________________

## HEALTH HISTORY

***For your safety and to assist us in accurately diagnosing and treating you, please carefully review this form completely and fill out all areas which pertain to you.***

**ALL INFORMATION IS PRIVATE AND CONFIDENTIAL**

### ■ DENTAL HISTORY

**Your Dentist:** __________ **City:** __________ **How Long:** _____

**Date of last visit:** __________ **Date of last dental cleaning:** __________ **Last F.M. X-Rays:** _____

**Check any of the following you have had or currently have:**

- ____ **Mouth Discomfort**
- ____ **Previous Periodontal Treatment**
- ____ **Trenchmouth or Pyorrhea**
- ____ **Gum Abscesses**
- ____ **Gums Bleed when Brushing**
- ____ **Loose or Shifting Teeth**
- ____ **Trouble in Chewing or Speaking**
- ____ **Bruise Easily**
- ____ **Grind or Clench your Teeth**
- ____ **Clicking, Popping or Pain in Jaw Joints**
- ____ **Orthodontic Treatment**
- ____ **Sensitive Teeth (heat/cold/sweets)**
- ____ **Awake with Sore Jaws**
- ____ **Mouth Odor or Bad Taste**
- ____ **Cold Sores or Fever Blisters**
- ____ **Other Oral Lesions**
- ____ **Had Immediate Relatives Lose All of their Natural Teeth**
- ____ **Bad Dental Experience**
- ____ **Complications With or Following Previous Dental or Oral Surgical Treatment**
- ____ **Fear of Dental Treatment**

______________________________

______________________________

**Do you want to keep your teeth?**

- ____ **Yes, no matter how much trouble**
- ____ **Yes, if it's not too much trouble**
- ____ **Don't know**
- ____ **Don't care**

*Please continue on reverse side ➜*

## ■ MEDICAL HEALTH HISTORY

1) HOW WOULD YOU DESCRIBE YOUR PRESENT HEALTH? Excellent Good Fair Poor (Circle One)

2) LIST YOUR CURRENT PHYSICIAN(S):

a) ______________________ Type ______________ How Long? __________

b) ______________________ Type ______________ How Long? __________

3) Date of last complete physical exam: __________ Purpose: ______________________

Findings: ______________________________ Height: ______ Weight: ______

| | Circle either No or Yes | | Explain |
|---|---|---|---|
| 4) Are you aware of any changes in your general health in the last year? | NO | YES | ______ |
| 5) Have you been hospitalized for illness or surgery in the past two years? | NO | YES | ______ |
| 6) Have you been under a medical doctor's care during the past two years? | NO | YES | ______ |
| 7) Have you ever had excessive bleeding that required special treatment? | NO | YES | ______ |
| 8) Is there any history of diabetes in your family? | NO | YES | ______ |
| 9) Are you required to restrict your work activity in any way? | NO | YES | ______ |
| 10) Are you on a special or restricted diet of any kind? | NO | YES | ______ |

11) DO YOU SMOKE? NO YES (Circle One) How Much? __________ How Long? __________

12) LIST ALL MEDICATIONS YOU ARE NOW TAKING (include all over the counter).

______________________________________________________________

______________________________________________________________

13) PLEASE CIRCLE ANY OF THE FOLLOWING MEDICATIONS YOU ARE ALLERGIC TO:

| | | | | | | |
|---|---|---|---|---|---|---|
| Penicillin | Vibramycin | Novocaine | Tylenol | Codeine | Valium | Other ______ |
| Erythromycin | Sulfa Drugs | Carbocaine | Aspirin | Demerol | Barbiturates | ______ |
| Tetracycline | Keflex | Xylocaine | Anesthetics | Morphine | Scopalamine | ______ |

## ■ **Indicate which of the following you have had or have at present.** Circle "NO" or "YES" to each item.

- Heart Trouble .......... NO YES
- Heart Disease or Attack .......... NO YES
- Angina .......... NO YES
- High Blood Pressure .......... NO YES
- Heart Murmur .......... NO YES
- Rheumatic Fever .......... No YES
- Congenital Heart Lesions .......... NO YES
- Artificial Heart Valve .......... NO YES
- Scarlet Fever .......... NO YES
- Heart Pacemaker .......... NO YES
- Heart Surgery .......... NO YES
- Shortness of Breath upon Mild Exertion .......... NO YES
- Require More than Two Pillows to Sleep .......... NO YES
- Ankles Swell .......... NO YES
- Anemia .......... NO YES
- Sickle Cell Disease .......... NO YES
- Artificial Joint (Knee, Hip) .......... NO YES
- Kidney Bladder Trouble .......... NO YES
- Thyroid Disease .......... NO YES
- Emphysema .......... NO YES
- Persistent Cough .......... NO YES
- Tuberculosis .......... NO YES
- Asthma .......... NO YES
- Hay Fever .......... NO YES
- Sinus Troubles .......... NO YES
- Allergies or Hives .......... NO YES
- Diabetes .......... NO YES
- Frequent Thirst and/or Urination . NO YES
- Stroke .......... NO YES
- Epilepsy or Seizures .......... NO YES
- Frequent Headaches .......... NO YES
- Fainting or Dizzy Spells .......... NO YES
- HIV Positive .......... NO YES
- Breast Implant(s) .......... NO YES
- Cancers or Tumors .......... NO YES
- Radiation Treatment .......... NO YES
- Chemotherapy .......... NO YES
- Arthritis/Rheumatism .......... NO YES
- Glaucoma .......... NO YES
- Contact Lenses .......... NO YES
- Hepatitis .......... NO YES
- Liver Disease .......... NO YES
- Jaundice .......... NO YES
- A.I.D.S. .......... NO YES
- Blood Transfusion .......... NO YES
- Drug/Alcohol Addiction .......... NO YES
- Hemophilia .......... NO YES
- Venereal Disease .......... NO YES
- A Nervous Person .......... NO YES
- Ulcers .......... NO YES
- Psychiatric Care .......... NO YES
- Unintentional Weight Gain/Loss .... NO YES

**Have you or are you currently taking osteoporosis meds? .......... NO YES**

## ■ If Female, are you:

Pregnant? .......... NO YES Through Menopause? .......... NO .......... YES

Taking Birth Control Pills? .......... NO YES Taking Hormone Medication? .......... NO .......... YES

## ■ Do you have any medical condition/disease not listed above that we should know about?

NO YES Explain

■ *To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any changes in my health or if my medicines change, I will inform the doctor on or before my next appointment, without fail.*

*I certify that I speak, read, and write English.* _____ *initial*

**I have fully understood this document.**

______________________________ ______________________________

Patient's Signature Date Doctor's Signature Date