Harbor Periodontics

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Periodontics · Implants · Micro Surgery · Laser Surgery

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NOTE TO PATIENT: These questions are for your benefit. They assure that any dental treatment in the future will take into consideration your past and present health status.

Name: _____ Birth Date: _____

Address: _____ Height: _____ Weight: _____

City _____ State _____ Zip _____ Referred by: _____

Social Security Number: _____ Regular Dentist (if not above):

E-mail Address _____ _____

Home Phone: _____ For how long: _____

Bus. Phone: _____ Cell Phone: _____ Physician: _____

Occupation: _____ Dental Insurance:

Employer: _____ _____

Business Address: _____ Emergency contact Name and phone number:

_____ _____ _____

Marital Status: _____ _____ _____

Spouse's Name (if applicable): _____ _____ _____

Spouse's Employer: _____ (Office use only) Blood Pressure: _____/_____

Spouse's S.S. #: _____ Birth Date: _____ Heart Rate: _____ Date: _____

MEDICAL HISTORY

Do you have, or have you had, any of the following?

☐ AIDS/HIV Positive	☐ Chest Pain	☐ Frequent Headaches	☐ Irregular Heartbeat	☐ Scarlet Fever
☐ Alzheimer's Disease	☐ Cold Sores/Fever Blisters	☐ Genital Herpes	☐ Kidney Problems	☐ Shingles
☐ Anaphylaxis	☐ Congenital Heart Disorder	☐ Glaucoma	☐ Leukemia	☐ Sickle Cell Disease
☐ Anemia	☐ Convulsions	☐ Hay Fever	☐ Liver Disease	☐ Sinus Trouble
☐ Angina	☐ Cortisone Medicine	☐ Heart Attack/Failure	☐ Low Blood Pressure	☐ Spina Bifida
☐ Arthritis/Gout	☐ Diabetes	☐ Heart Murmur	☐ Lung Disease	☐ Stomach/Intestinal Disease
☐ Artificial Heart Valve	☐ Drug Addiction	☐ Heart Pacemaker	☐ Mitral Valve Prolapse	☐ Stroke
☐ Artificial Joint	☐ Easily Winded	☐ Heart Trouble/Disease	☐ Pain In Jaw Joints	☐ Swelling of Limbs
☐ Asthma	☐ Emphysema	☐ Hemophilia	☐ Parathyroid Disease	☐ Thyroid Disease
☐ Blood Disease	☐ Epilepsy or Seizures	☐ Hepatitis A	☐ Psychiatric Care	☐ Tonsillitis
☐ Blood Transfusion	☐ Excessive Bleeding	☐ Hepatitis B or C	☐ Radiation Treatments	☐ Tuberculosis
☐ Breathing Problem	☐ Excessive Thirst	☐ Herpes	☐ Recent Weight Loss	☐ Tumors or Growths
☐ Bruise Easily	☐ Fainting Spells/Dizziness	☐ High Blood Pressure	☐ Renal Dialysis	☐ Ulcers
☐ Cancer	☐ Frequent Cough	☐ Hives or Rash	☐ Rheumatic Fever	☐ Venereal Disease
☐ Chemotherapy	☐ Frequent Diarrhea	☐ Hypoglycemia	☐ Rheumatism	☐ Yellow Jaundice

1. Have you come to this office for relief of pain? YES_____ NO_____
2. How would you describe your present health? Excellent_____ Good_____ Fair_____ Poor_____ Don't Know_____
3. Has there been any change in your general health in the last year? YES_____ NO_____
   Explain: _____
4. Have you been under a doctor's care during the past two years? YES_____ NO_____
   Explain: _____
5. Have you been hospitalized or seriously ill? YES_____ NO_____
   Explain: _____
6. Do you take any kind of medicines or drugs? YES_____ NO_____
   List: _____
7. Do you take or have you taken Phen-fen or Redux? YES_____ NO_____

8. Are you allergic to the following?

___Aspirin ___Penicillin ___Codeine ___Acrylic ___Metal ___Latex ___Local Anesthetics ___Other _____ None ____

9. Have you ever had excessive bleeding that required special treatment? YES_____ NO_____
10. Is there any history of diabetes in your family? YES_____ NO_____
11. Are you required to restict your work or activity in any way? YES_____ NO_____
12. Do you wear contact lenses? YES_____ NO_____
13. Are you on a special or restricted diet of any kind? YES_____ NO_____
14. Have you ever been treated for a growth or tumor in any part of your body? YES_____ NO_____
15. Have you been under more nervous tension than average lately? YES_____ NO_____
16. Do you smoke? YES_____ NO_____

WOMEN:

17. Are you pregnant? YES_____ NO_____
18. Is your menstrual cycle regular? YES_____ NO_____
19. Have you reached menopause? YES_____ NO_____
20. If so, do you have any symptoms? YES_____ NO_____

Describe: _____

21. How many pregnancies have you had?_____

Do you have any disease, condition or problems not listed above that you feel we should know about? If so, please explain _____

DENTAL HEALTH HISTORY

1. How would you describe your dental health?_____
2. Do you think your teeth are affecting your general health in any way? YES_____ NO_____
3. Have you had personal instruction on proper oral hygiene? YES_____ NO_____
4. Do you feel your present oral hygiene is effective in cleaning your mouth? YES_____ NO_____
5. Are you satisfied with the appearance of your teeth? YES_____ NO_____
6. When was your last visit to the dentist? _____
7. When did your last have your teeth cleaned? _____
8. Have you ever had x-ray or surgery treatment for a tumor, growth, or other condition about your head, mouth or on your lips? YES_____ NO_____
9. Have you ever had any injury to your face or jaws? YES_____ NO_____
10. Have you ever had an acutely sore mouth? YES_____ NO_____
11. Have you ever had sores in your mouth that are slow to heal? YES_____ NO_____
12. Have you experienced pain in your teeth because of heat, cold, or sweets? YES_____ NO_____
13. Have you had swollen areas of the gums? YES_____ NO_____
14. Have you ever had periodontal (gum) treatments? YES_____ NO_____
15. Have you had previous orthodontic treatment (braces)? YES_____ NO_____
16. Have you ever had your teeth ground or the bite adjusted? YES_____ NO_____
17. Have you ever worn a bite plate or other appliance? YES_____ NO_____
18. Do your gums bleed easily? YES_____ NO_____
19. Have you noticed any loose teeth? YES_____ NO_____
20. Have you noticed any change in the position of your teeth lately? YES_____ NO_____

21. Do you have difficulty in chewing? YES_____ NO_____

Why? _____

22. Are you aware of clenching, gritting, or grinding your teeth together in the daytime, or at night in your sleep? YES_____ NO_____

23. Do you awaken in the morning with your teeth together? YES_____ NO_____

Do you have the following symptoms? (underline)

tired jaw tired or sore jaw muscles ache in face ache in jaw joint clicking in jaw

24. Do you have difficulty in opening your mouth wide? YES_____ NO_____

25. Are you worried about receiving dental treatment? YES_____ NO_____

26. Have you ever had a bad experience in a dental office? YES_____ NO_____

Explain: _____

_____

I acknowledge that all of the preceding questions have been carefully and accurately answered. Furthermore, I understand that I am responsible for payment of all charges for treatment and that should my account be referred to an attorney for collection, reasonable attorney's fees of 20% shall be added to the account in addition to interest of 1.5% per month on the outstanding balance.

KINDLY GIVE 24 HOURS NOTICE IF UNABLE TO KEEP NON-SURGICAL APPTS & 7 DAYS FOR SURGICAL APPTS. OTHERWISE A CHARGE WILL BE MADE FOR TIME RESERVED

Signature:_____ Date:_____

OFFICE USE:

Chief Oral Complaint:_____ present DDS:_____ how long? _____

sensitivity:_____ DDS requests: _____

bleeding:_____ last scaled:_____ freq.: q_____ mos. for_____ yrs.

swelling:_____ pattern of dental care: regular sporadic infrequent

pain: _____ _____

tooth mobility: _____ _____

other:_____

Personal Oral Care: Brushes_____ per day with S M H brush. Flosses_____ per week with WF UWF Tape

Other POH:_____ Significant oral habits: _____

Smokes_____ cigarettes cigars pipe per day - week. POH attitude:_____

Needs related to teeth: retention_____ esthetics_____ function_____ comfort_____ other_____

Receptivity to dental or surgical treatment?_____

Soft Tissue Findings:

Region	WNL	Deviation
Head	☐	_____
Neck	☐	_____
Lips	☐	_____
Skin	☐	_____
Floor of mouth	☐	_____
Buccal Mucosa	☐	_____
Palate	☐	_____
Oropharynx	☐	_____
Tongue	☐	_____

TMJ- Muscle Spasm: R - M, PT^{I}, T PT^{E}

L - M, PT^{I}, T PT^{E}

Deviation on Opening: R, L

Opening Distance: mm

Joint Click: