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Patient Demographics

Last ______________ First ______________ Middle ______________

Preferred __________ Title __________ ❑ Male ❑ Female ❑ Single ❑ Married ❑ Child ❑ Other

Birth Date __________ S.S.# __________ Drivers License # __________

Address ______________________________

Address ______________________________

City ______________ State __________ Zip __________

E-mail ______________ Home Phone ______________

Work Phone __________ Ext. __________ Best time to call __________

Fax __________ Pager/Cell __________ Other __________

Employer Information

Employer Name ______________ Phone ______________

Address ______________ Occupation ______________

Address ______________________________

City ______________ State __________ Zip __________

Insurance Information

Primary

Name of Insured ______________ Is insured a patient? ❑ Yes ❑ No

Birth Date __________ ID# or SSN __________ Group# __________

Insured's Employers Name ______________ Phone# ______________

Patient's relationship to insured ❑ Self ❑ Spouse ❑ Child Other __________

Insurance Plan Name ______________________________

Address ______________ City __________ State __________ Zip __________

Phone # ______________________________

Whom may we thank for referring you to our practice? ______________

Phone# ______________________________

In case of emergency, please contact Name ______________

Home Phone ______________ Work Phone ______________

Medical History

Do you now or have you ever had any of the following? **Please answer yes or no to ALL questions**.

* If yes to any of the starred conditions, please call prior to your appointment, premedication may be required.

	Yes	No		Yes	No		Yes	No
Anemia	❑	❑	Fainting Tendency	❑	❑	Lung Disease	❑	❑
Angina/Chest Pain	❑	❑	Fever Blisters	❑	❑	Mitral Valve Prolapse*	❑	❑
Artificial Heart Valve*	❑	❑	Frequent Cough	❑	❑	Nervousness	❑	❑
Aspirin Therapy (Taken Daily)	❑	❑	Frequent Diarrhea	❑	❑	Pain in Jaw Joints	❑	❑
Asthma	❑	❑	Glaucoma	❑	❑	Plavix	❑	❑
Alzheimer's Disease	❑	❑	Grind Teeth	❑	❑	Psychiatric Care	❑	❑
Arthritis/Gout	❑	❑	Heart Attack/Failure	❑	❑	Recent Blood Transfusion	❑	❑
Artificial Joint*	❑	❑	Heart Murmur*	❑	❑	Renal Dialysis	❑	❑
Bleeding Tendency	❑	❑	Heart Pacemaker*	❑	❑	Rheumatic/Scarlet Fever*	❑	❑
Blood Disease	❑	❑	Heart Problems	❑	❑	Rheumatoid Arthritis	❑	❑
Breathing Problem	❑	❑	Heart Surgery	❑	❑	Seizures or Epilepsy	❑	❑
Bruise Easily	❑	❑	Hemophilia	❑	❑	Shortness of breath when lying down	❑	❑
Cancer; Type ________________	❑	❑	Hepatitis Circle one A B C	❑	❑	Sickle Cell Anemia	❑	❑
Chemotherapy	❑	❑	Herpes	❑	❑	Sinus Trouble	❑	❑
Cold Sores	❑	❑	HIV/AIDS	❑	❑	Stomach/Intestinal Disease	❑	❑
Congenital Heart Disorder	❑	❑	High Blood Pressure	❑	❑	Stroke	❑	❑
Convulsions	❑	❑	High Cholesterol	❑	❑	Thyroid Disease	❑	❑
Cortisone Medication	❑	❑	Hives	❑	❑	Tuberculosis	❑	❑
Coumadin	❑	❑	Hypoglycemia	❑	❑	Tumors or Growths	❑	❑
Diabetes/Family History of Diabetes	❑	❑	Kidney Problems	❑	❑	Ulcers	❑	❑
Drug Addiction/Alcoholism	❑	❑	Leukemia	❑	❑	Women (Taking Oral Contraceptives?)	❑	❑
Emphysema	❑	❑	Liver Problems	❑	❑	X-Ray Treatments (Radiation)	❑	❑

Have you ever had any other serious illness not checked above? Discuss ______________________________

	Yes	No
Is your past and present health good?	❑	❑
Are you pregnant/nursing?	❑	❑
Are you allergic to any medications?	❑	❑

❑ Aspirin ❑ Penicillin ❑ Codeine ❑ Acrylic ❑ Metal
❑ Latex Rubber ❑ Dental anesthesia, gas or novocaine
❑ Other______________________________

	Yes	No
Do you ❑ smoke ❑ chew ❑ dip	❑	❑
Have you ever had to premedicate with antibiotics prior to Dental Care?	❑	❑

Dental- Periodontal History

	Yes	No
Have you ever been treated for periodontal problems before? If so, when? ______________	❑	❑
Unpleasant taste and/or odor in your mouth?	❑	❑
Is there any family history of periodontal problems?	❑	❑
Do your gums bleed?	❑	❑
Do you have pain in your gums?	❑	❑
Do you gag easily?	❑	❑
Do your gums feel swollen?	❑	❑

When was your last Dental Cleaning? ______________

	Yes	No
Do you have pain/sensitivity in your teeth?	❑	❑

Brush ______ times a day with:
❑ Soft ❑ Medium ❑ Hard brush.

Is your toothbrush hand held or electric? ____________

Floss ______ times a day with:
❑ Unwaxed ❑ Waxed ❑ by Hand ❑ Holder

Brush & floss: ❑ Morning ❑ Noon ❑ After Dinner ❑ Bedtime

Please list any medications you are taking and their dosages: ______________________________

____

Physician's name/phone # ______________________________ Date of last physical examination __________

Is there any other medical information that we should know that would be pertinent to our treating you? ______________

____

To the best of my knowledge, all of the preceeding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor at the next appointment without fail. I, the undersigned (Patient or Legal Guardian), authorize Periodontal Treatment to be rendered and assume financial responsibility.

Signature ____

Date ____________________

Dental Health History

Have you or do you currently take Bisphosphonates (Fosamax, Boniva)? ....Yes___ No_____

Have you been diagnosed with Osteoporosis or Osteopenia? .... Yes___ No_____

How would you describe your dental health? ____

Do you think your teeth are affecting your general health in any way?...Yes___ No___

Have you had personal instruction on proper oral hygiene?...Yes___ No___

Do you feel your present oral hygiene is effective in cleaning your mouth?....................................Yes___ No___

Are you satisfied with the appearance of your teeth?...Yes___ No___

How frequently do you have dental cleanings? _______________

Have you ever had x-rays or surgery treatment for a tumor, growth, or other condition about your head, mouth or On your lips?...Yes___ No___

Have you ever had any injury to your face or jaws?..Yes___ No___

Have you ever had an acutely sore mouth?..Yes___ No___

Have you ever had sores in your mouth that are slow to heal?..Yes___ No___

Have you had previous orthodontic treatment (braces)?..Yes___ No___

Have you ever had your teeth ground or bite adjusted?...Yes___ No___

Have you ever worn a bite plate or other appliance?...Yes___ No___

Have you noticed any loose teeth?..Yes___ No___

Have you noticed any change in the position of your teeth lately?...Yes___ No___

Do you have difficulty chewing?..Yes___ No___

Why? ____

Are you aware of clenching, gritting, or grinding your teeth together in the daytime, or night in your sleep?...
Yes___ No___

Do you awaken in the morning with your teeth together?.. Yes___ No___

Do you have the following symptoms?

Tired jaw___ tired/sore jaw muscles___ ache in face___ ache in jaw joint___ clicking in jaw___

Do you have difficulty in opening your mouth wide?...Yes___ No___

Are you worried about receiving dental treatment?...Yes___ No___

Have you ever had bad experience in a dental office?...Yes___ No___

Explain:

____

I acknowledge that all 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 collections, 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.

Signature:____ Date__________

Office Use Only:

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: