Patient Information

Patient Name _____Date _____

Gender M F Date of Birth (mo/day/year) _____ Social Security # _____

Email _____Home Phone (landline only) _____Mobile (text)_____

Preferred Method of Contact (check box) ☐ Email ☐ Home Phone (automated call) ☐ Mobile Text

Address _____ Apartment #_____

City _____ State _____ Zip _____----
_____

Employer _____ Occupation
_____

Emergency Contact _____Phone _____ Relationship
_____

Responsible Party Information (if patient is under age 18)

Name
_____

Gender M F Date of Birth (mo/day/year) _____ Social Security #
_____

Phone (Home) _____ Work _____ Cell _____

Address _____City _____ State _____ Zip
_____

Employer Name _____ Address _____ Phone
_____

Dental Insurance Information

PRIMARY PLAN

Carrier_____ Carrier phone_____

Carrier address_____

Subscriber_____ Employer_____

Soc Sec #_____ Birth date_____ Group #_____

SECONDARY

Carrier_____ Carrier phone_____

Carrier address_____

Subscriber _____Employer_____

Soc Sec #_____ Birth date_____ Group #_____

Important Dental Information

Although some of the following questions may seem unrelated to your teeth, they are associated with proper management of your oral health and are confidential.

Name of General Dentist _____City_____ Date of last cleaning_____

Have you had previous periodontal treatment? ☐ Yes ☐ No

Are you having any dental pain or discomfort? ☐ Yes ☐ No

Are you apprehensive about dental work? ☐ Yes ☐ No If yes, please explain
_____

Do you have any suggestions on how we can make your periodontal treatment less stressful and more comfortable for you?

_____
_

Have you been advised by your physician to pre-medicate with antibiotics prior to dental treatments? ☐ Yes ☐ No

If yes, which medication? _____Why prescribed? _____

Check all that apply

☐ Bad Breath	☐ Clenching	☐ Painful Gums	☐ TMJ
☐ Bad Taste	☐ Difficulty Chewing	☐ Receding Gums	☐ Grinding
☐ Bleeding Gums	☐ Frequent Headaches	☐ Sensitive Teeth	☐ Dry Mouth

Health Information

Name of Primary Care Physician _____ Phone _____

Date of last physical exam _____ Results _____

Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No

If yes, please explain: _____

Please list any medications, including non-prescription drugs, taken on a regular basis

_____

Have you had surgery or X-Ray treatment for a tumor, growth or other conditions of your head, mouth, or lips? ☐ Yes ☐ No

Are you currently or have you taken? ☐ Actonel ☐ Aridia ☐ Boniva ☐ Fosamax ☐ Zometa

Have you ever had bleeding or difficulty with blood clotting? ☐ Yes ☐ No
Are you taking blood thinners (i.e. Coumadin)? ☐ Yes ☐ No If Yes, last INR Level (_____) Date: _____
Do you take Aspirin? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No If yes, for how long_____) (packs per day_____)

Do you drink alcohol? ☐ Yes ☐ No If yes, drinks per month_____), week_____), day_____)

Do you use recreational drugs? ☐ Yes ☐ No If yes, for how long_____) which drug:_____

For Women Only: *Some medications used in dentistry will cross the placental and breast milk barrier, and might affect the unborn fetus. Antibiotic use may reduce the effectiveness of birth control pills, and alternate methods are recommended if taking them.*

Have you reached menopause? ☐ Yes ☐ No
Are you using hormone replacement therapy (HRT)? ☐ Yes ☐ No
Do you use birth control pills, injection ☐ Yes ☐ No (which one) _____
Are you pregnant at the present time? ☐ Yes / Due Date _____ ☐ No ☐ Possibly
Are you breastfeeding at the present time? ☐ Yes ☐ No

Have you ever had any of the following? Please check those that apply

- ☐ AIDS
- ☐ Allergies _____
- ☐ Artificial Heart Valve
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
  Month:___ Year: _____
- ☐ Asthma
- ☐ Bacterial Endocarditis
- ☐ Cancer
- ☐ **Diabetes**
  Type _____
  Last A1C Level _____
  Date of Test: (_____)
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis Type____
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Organ Transplant
- ☐ Pacemaker
- ☐ Prostate Disorder
- ☐ Prosthetic Implant
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Seizures/Convulsions
- ☐ Sinus Problems
- ☐ Sleep Apnea
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease

- ☐ C-Diff
- ☐ COPD

- ☐ OTHER
  _____

Have you ever had an adverse reaction or allergy to any of the following

- ☐ Aspirin
- ☐ Anti-Inflammatory Medication
- ☐ Codeine Allergy
- ☐ Dental Anesthetics
- ☐ Latex Materials
- ☐ Penicillin Allergy
- ☐ Percodan Allergy
- ☐ Valium/Tranquilizers
- ☐ Other

Type of reaction to above med _____Are there medications that you cannot take _____

To the best of my knowledge, the information provided is true and correct. I understand that all appointments require 48 business hour cancellation notice.

_____ _____

Signature of patient, parent or guardian **Date**