PATIENT INFORMATION

Today's Date: _____

Patient Name: _____
What would you prefer to be called: _____
Social Security Number: _____ Date of Birth: _____
Phone Number: _____ Cell Phone: _____
E-Mail: _____
To confirm your appointment, would you prefer: ☐Phone Call ☐E-mail ☐Text
Address: _____
City: _____ State: _____ Zip: _____

Employer: _____ Work Phone: _____
Employer Address: _____
City: _____ State: _____ Zip: _____

Emergency Contact: _____ Phone: _____

Who referred you? _____ Phone: _____

Present Dentist: _____ Phone: _____
Last Visit: _____

Briefly state the reason for your visit: _____
Have any family or friends been treated here? Yes ☐ or No ☐
If yes, who? _____

I have answered these questions to the best of my knowledge.

Patient Signature: _____ Date: _____

There will be a charge for appointments that are cancelled with less than *48 working hours* advance notice.

DENTAL HISTORY

YES or NO

☐ ☐ Are you experiencing any discomfort at this time? If yes, explain: _____

_____

When did you last have your teeth cleaned? _____

☐ ☐ Have you made regular visits?

☐Once a Year ☐Every 6 Months ☐Every 3 Months ☐Other

How long have you known about your gum condition? _____

What type of treatment have you had previously?

☐Regular Cleanings ☐Deep Cleaning/ Root Planning ☐Gum Surgery

☐ ☐ Do your gums bleed or hurt? If yes, when: _____

☐ ☐ Are any of your teeth sensitive to:

☐Hot ☐Cold ☐Sweets ☐Pressure

☐ ☐ Are any of your teeth loose? _____

☐ ☐ Does food get caught between your teeth? If yes, where: _____

_____

☐ ☐ Are you conscious of bad taste or bad breath?

☐ ☐ Have you noticed spaces developing between your teeth?

☐ ☐ Have you noticed your bite changing?

☐ ☐ Does tartar and stain return quickly?

☐ ☐ Do you have a family history of gum disease?

How often do you brush your teeth?

☐1x day ☐2x day ☐3x day ☐3x day++

What kind of toothbrush do you use?

☐Soft ☐Medium ☐Hard ☐Electronic

How often do you floss your teeth?

☐ Never ☐I just started ☐Occasionally ☐1x ☐2x ☐3x

☐ ☐ Do you use mouthwash? If yes, what type and how often?

_____

☐ ☐ Do you use anything else to clean your teeth?

☐Toothpick ☐Proxabrush ☐Waterjet Other: _____

☐ ☐ Have you ever been told that you have TMJ problems?

☐ ☐ Have you ever been given a splint to wear?

☐ ☐ Do you have a popping, clicking, grinding, or soreness in the joints in front of your ears?

☐ ☐ Do you clench or grind your teeth?

☐ ☐ Do your jaws feel stiff, sore, or tired when you awaken or at the end of the day?

☐ ☐ Have you had any of the following dental treatments:

☐Orthodontics (braces)

☐ Endodontic (root canal treatment)

☐ Oral (jaw) surgery

MEDICAL HISTORY

Periodontal Disease is influenced by a combination of factors. Successful treatment depends on their identification. The following questions are pertinent to the diagnosis of your periodontal condition. All information will be held in confidence.

Date of last physical examination: _____
Physician's name: _____ Phone number: _____
Address: _____
City:_____ State:_____ Zip:_____

Are you now under the care of a physician: Yes ☐ or No ☐
If yes, what condition is being treated? _____

Do you take any medicines or drugs (i.e. aspirin, vitamins, recreational drugs, or hormones)? Please list: _____
Do you have a history of any type of substance abuse? Yes ☐ or No ☐
Please list any medications that you are allergic to: _____
_____

Does aspirin or ibuprofen (Motrin) irritate your stomach? Yes ☐ or No ☐
Have you ever had any adverse reactions to antibiotics, local anesthetics, drugs, or any kind of sedatives? Yes ☐ or No ☐. If yes, please list: _____
_____

Have you ever had excessive bleeding that required special treatment:Yes ☐ or No ☐
Have you ever had a blood transfusion? Yes ☐ or No ☐
If yes, please explain the circumstances and when: _____
_____

Are you on a special or restricted diet of any kind?_____

Do you use any tobacco products? No ☐ or Yes ☐ If yes, how much per day? _____
Type: Cigarettes☐ Cigars☐ and/or Smokeless☐
Do you drink alcohol? No ☐ or Yes ☐ If yes, how often? _____

Are you experiencing unusual stress or pressure at work or at home? Yes ☐ or No ☐

Have you ever been treated with Botox of dermal filler? Yes ☐ or No ☐

WOMEN:
Are you pregnant or trying to become pregnant? Yes ☐ or No ☐
Are you currently breastfeeding? Yes ☐ or No ☐
Are you taking birth control pills or hormone supplements? Yes ☐ or No ☐

CONDITIONS FORM

Do you have or have you had any of the following diseases or problems? Check all that apply.

- ☐ Heart failure
- ☐ Heart disease or attack
- ☐ Angina Pectoris
- ☐ Pain or tight feeling in chest
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Heart murmur*
- ☐ Mitral valve prolapse*
- ☐ Rheumatic fever*
- ☐ Congenital heart lesions*
- ☐ Scarlett fever
- ☐ Artificial heart valve*
- ☐ Heart pacemaker
- ☐ Heart surgery
- ☐ AIDS
- ☐ HIV positive
- ☐ Hepatitis A (infectious)
- ☐ Hepatitis B (serum)
- ☐ Liver disease
- ☐ Yellow jaundice
- ☐ Emphysema
- ☐ Tuberculosis (TB)
- ☐ Asthma
- ☐ Hay fever
- ☐ Sinus trouble
- ☐ Allergies or hives
- ☐ Artificial joints*
- ☐ Anemia or other blood problems
- ☐ Stroke
- ☐ Kidney disease*
- ☐ Ulcers - stomach or intestinal
- ☐ Bruise easily
- ☐ Sickle cell disease
- ☐ Psychiatric treatment
- ☐ Nervousness
- ☐ Diabetes
- ☐ Excess thirst
- ☐ Low blood sugar
- ☐ Thyroid disease - hypo/hyper-
- ☐ X-ray or cobalt treatment
- ☐ Chemotherapy (cancer, leukemia)
- ☐ Arthritis
- ☐ Rheumatism
- ☐ Cortisone medication
- ☐ Pain in jaw joints
- ☐ Chronic headaches
- ☐ Fainting or dizzy spells
- ☐ Neurological problems/epilepsy
- ☐ Cold sores (herpes)
- ☐ Venereal disease (syphilis, gonorrhea)
- ☐ Osteoporosis medicine (i.e. Fosamax, Actonel, Reclast, Boniva, etc.)

*Has a physician directed you to take antibiotics prior to having your teeth cleaned?
Yes ☐ or No ☐

Is there anything else we should know about your health? ☐ Yes or ☐ No

Would you like to speak to the doctor privately about any problems? ☐ Yes or ☐ No

I have answered all of the preceding questions to the best of my knowledge. If my health or medication changes, I will inform the dentist at my next appointment.

Patient signature: _____ Date: _____