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SPECIALIST IN PERIODONTICS | DIPLOMATE AMERICAN BOARD OF PERIODONTOLOGY

Patient's Name: _____ **Date**: _____
LAST FIRST MIDDLE

Address: _____
STREET CITY STATE ZIP

Email: _____

Birthdate: _____/_____/_____ **Home Phone**: _____**Cell**: _____

If patient is a minor, name of parent or guardian: _____

Whom may we thank for referring you to us? _____

Responsible Party Information

Name: _____ _____
LAST FIRST MIDDLE MARITAL STATUS

Mailing Address: _____
STREET CITY STATE ZIP

*__Home Phone__: _____ **Work Phone:** _____**Cell**: _____
**** *Please circle the preferred phone number to contact you*

Email: _____

SS#_____ **Birthdate:** _____/_____/_____ **Employer**_____

Occupation: _____ **Work Number**: _____**Years Employed**: _____

Dental Insurance Information

Insured's Name: _____ **SS #:** _____

Insurance Company: _____**Group #:** _____**Phone #:** _____

Insurance Company Address: _____

Do you have dual coverage? _____YES _____NO

If yes, Insurance Company Name and Address: _____

Group #: _____Phone #: _____

Name and Address of preferred pharmacy:
Name & Phone Number of the nearest relative not in your home: _____
Name of General Dentist:
Person to contact in case of an emergency: _____Phone #: _____

DENTAL HISTORY

Describe your main concern (why you made an appointment) _____
Have you had previous "gum trouble" and / or gum treatment? YES NO If yes, please explain _____
Do you see a dentist regularly? YES NO Who is your general dentist _
Any unusual reaction to dental anesthesia YES NO if yes, what reaction?_____
When were your teeth last "cleaned"? _____ Where? _____
How frequent is this usually done? _____Have any of your immediate relatives lost their teeth to periodontal disease? _____
How often do you brush your teeth? _____ DO you floss? YES NO

ORAL HABITS AND SYMPTOMS: Do you:

Clench or grind your teeth? YES NO
Have teeth that are shifting or loose ? YES NO
Have areas where food impacts between teeth? YES NO
Have soreness in the joints next to your ears? YES NO
Have sore, tender or bleeding gums? YES NO
Have teeth sensitive to hot, cold or sweets? YES NO

FEMALES ONLY:

Are you pregnant? YES NO Nursing? YES NO
Have you been through menopause? YES NO
Are you taking birth control pills? YES NO Hormonal Supplements? YES NO

GENERAL HEALTH HISTORY Vitals: BP: ___PR:___SPO2:___RR: Temp:_____ Ht:_____Wt:_____BMI:____

DO YOU HAVE, OR HAVE YOU EVER HAD:

Mitral Valve Prolapse YES NO
Rheumatic Fever YES NO
Rheumatic Heart Disease YES NO
Congenital Heart Failure YES NO
Congenital Heart Defect YES NO
Heart Murmur YES NO
Heart surgery or Pacemaker YES NO
Artificial Heart Valve YES NO
Artificial Joint (hip/knee) YES NO

Heart Disease: High Blood Pressure, Heart Attack, Angina, Stroke, Bypass? (*circle*) when? _____
COVID19 YES NO If yes, where you hospitalized? YES NO
Been under the care of a physician in the last year? YES NO Reason: _____Physician's name:_____
Major illness or operation? YES NO Reason: _____Date: _____
Ever fainted? YES NO Reason: _____ Date: _____
Taken steroids or cortisone? YES NO Reason: _____ Date: _____
Hepatitis / Liver Disease YES NO Tested positive to HIV antibodies, have AIDS, or been exposed to AIDS? YES NO
Had abnormal bleeding tendencies ("free bleeder", hemophilia, or prolonged bleeding after a tooth extraction? YES NO
Cancer: YES NO How were you treated? _____ Location of tumor_____ When: _____
Diabetes YES (I / II) NO Asthma YES NO Stomach Ulcers YES NO Glaucoma YES NO Thyroid problems YES NO
Anesthesia History YES NO If yes, describe : _____
Arthritis or rheumatism YES NO Osteoporosis YES NO Epilepsy, seizures YES NO Kidney disease YES NO
Blood disorder / anemia YES NO Venereal disease /STI YES NO Psychiatric Treatment YES NO
Drug or alcohol dependence YES NO Sinus Problems YES NO
Do you have any disease, condition, or problem not listed? YES NO If yes, please list: _____
How many cigarettes do you smoke daily? ____How many years? _____Smokeless tobacco? YES NO Alcohol YES NO

Please list your prescribed Medications / Over the counter / Supplements / Recreational Drugs:

Name: _____ Reason: _____ Dose: _____
Name: _____ Reason _____ Dose: _____
Name: _____ Reason: _____ Dose: _____

Are you allergic or have you ever had an adverse reaction to: (circle)
Penicillin Tetracycline Sulfa Codeine Anesthetics Epinephrine Sedatives Latex Aspirin Iodine Other: _____

To my knowledge I have given an accurate report of my physical and medical history. I understand this information is strictly confidential and it is necessary in order to properly treat my periodontal condition. I have also reported any prior allergic or unusual reactions, or any other abnormal conditions related to my health. I also consent to have any radiographs, 3D scan and /or photographs that my doctor recommends during the course of my treatment.

Patient Signature (or guardian if minor) Date:

Reviewed by: _____ Date: _____

All information is requested in order that I may thoroughly diagnose/treat your condition. All information will be held in strict confidence. Any discussion of your case with other professionals will be done only to enable a complete and comprehensive diagnosis and treatment plan and will be done only in the best interest and benefit for you. *Initial*_____