

PATIENT INFORMATION

Date _____

Name _____ Home Phone () _____

Street _____

City _____ State _____ Zip _____

Date of birth _____ Sex _____ SSN _____

Employer _____ Work phone _____

Street _____

City _____ State _____ Zip _____

INSURANCE INFORMATION

Do you have dental insurance? Yes No

REFERRAL INFORMATION

Referred by _____ Family Dentist _____

Physician _____ Last Seen / Reason _____

DENTAL HISTORY

1. What is your biggest concern about your gums, mouth, or teeth?
2. When was your last visit to your family dentist and what was the nature of the treatment?
3. Have you had periodontal treatment before? If yes, when and where?
4. How often and when is the last time your teeth were cleaned?

Check the following conditions if they apply to you

<input type="checkbox"/> swollen or bleeding gums	<input type="checkbox"/> bad breath or mouth odors	<input type="checkbox"/> bad tastes
<input type="checkbox"/> painful gums or teeth	<input type="checkbox"/> sensitivity to hot, cold, or sweets	<input type="checkbox"/> clench or grinding of your teeth
<input type="checkbox"/> loose teeth	<input type="checkbox"/> increasing spaces between teeth	<input type="checkbox"/> other _____

5. How would you feel if you had to lose your teeth?

IMPORTANT: Have you ever been treated for thin bones (**Osteoporosis, Osteopenia**)? If yes, please check:

ACTONEL _____	FOSAMAX _____	BONIVA _____	ZOMETA _____
SKEUD _____	OSTAC _____	BONEFOS _____	DIDRONEL _____

MEDICAL HISTORY

<i>Place check in the YES or NO column</i>	YES	NO						
1. Are you allergic to any medications? _____	___	___						
2. Have you had any serious illness, operation, or hospitalization in the past?	___	___						
3. Has there been a change in your health in the last 2 years?	___	___						
4. Are you a "bleeder" or have you had excessive bleeding following dental treatment?	___	___						
5. Are you presently under the care of a physician?	___	___						
6. Do you smoke or use tobacco products? How much? _____ How long? _____	___	___						
7. Do you drink alcoholic beverages?	___	___						
8. HAVE YOU HAD ANY OF THE FOLLOWING:								
	YES	NO	YES	NO	YES	NO		
High Blood Pressure	___	___	Angina	___	___	Aids or related Complex	___	___
Heart Murmurs	___	___	Heart Attack	___	___	Blood disorders	___	___
Prolapsed Mitral Valve	___	___	Pacemaker	___	___	Joint Implants	___	___
Rheumatic Fever	___	___	Emphysema	___	___	Nervous Disorders	___	___
Heart Problems	___	___	Asthma	___	___	Epilepsy / Seizures	___	___
Heart Bypass Surgery	___	___	Dialysis	___	___	Steroids Last 2 Years	___	___
Kidney Disease	___	___	Tuberculosis	___	___	Radiation / Chemo	___	___
Chemical Dependency Treatment	___	___	Stroke	___	___	H.I.V. Positive	___	___
Hepatitis / Liver Disease	___	___	Diabetes	___	___			
Oral Surgery Complications	___	___	Arthritis	___	___	Women Only:		
Thyroid Disorders	___	___	Headaches	___	___	Pregnant	___	___
Bleeding Problems	___	___	Cancer	___	___	Breast Feeding	___	___

9. List **ANY** drugs or medicines that you are currently taking.

DRUG	DOSAGE / HOW OFTEN?	HOW LONG?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PATIENT SIGNATURE _____ Date _____

TO BE FILLED IN BY DOCTOR

MEDICAL HISTORY REVIEWED / UPDATED ON: _____ BY _____