NEW PATIENT INFORMATION

Please print. Date _____

Please answer the following completely. Your answers are for our records and they are considered confidential.

Patient's Name _____ **Age** _____

Marital Status _____ **Date of Birth** _____ **S.S.#** _____

Name of Spouse _____ **Patient Email address**_____

If a Child, Parent's Name(s) _____ **Weight of Child**_____

Residence Address _____ **City** _____ **State** _____ **Zip** _____

Telephone:Residence _____ **Business**: _____ **Cell**: _____

Employed By: _____ **Business Address**:_____

Spouse Employed By: _____**Business Tel:**_____

Whom may we thank for referring you?_____

Person Responsible for Payment of Account_____
(*and address if different than above*)

Emergency Contact Info:

Person to contact in case of an emergency _____ **Telephone**_____

Dental Insurance Info:

(WE DO NOT FILE MEDICAL OR MEDICAID INSURANCE OR SECONDARY INSURANCE)

Subscriber: _____ **S.S.#/ID #:** _____ **DOB:** _____

Group #: _____ **Employer:** _____ **Ins. Company:** _____

Ins. Co. Address: _____ **City**: _____

State: _____ **Zip**: _____ **Ins. Co. Telephone Number**: _____
(Please provide copy of dental insurance card at appointment if available)

Patient's relationship to insured: ☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **Other** _____

HEALTH QUESTIONNAIRE

Answers to the following questions are for our records and will be considered confidential.

1. **Are you presently under the care of a physician? ☐ Yes ☐ No Name and address of physician** _____

   _____ **Phone** _____ **If so for what condition are you being treated?** _____

2. **Have you had abnormal bleeding associated with previous extractions, surgery or trauma? ☐ Yes ☐ No**

3. **Are you allergic to or have you reacted adversely to:**

   a. ☐ Yes ☐ No **Local Anesthetics (Novocaine)?**
   b. ☐ Yes ☐ No **Aspirin?**
   c. ☐ Yes ☐ No **Nitrous oxide analgesia?**
   d. ☐ Yes ☐ No **Penicillin or other antibiotics?** _____
   e. ☐ Yes ☐ No **Codeine or other narcotics?** _____
   f. ☐ Yes ☐ No **Latex?**

4. **Do you wear a pacemaker? ☐ Yes ☐ No** **Do you have vascular stents? ☐ Yes ☐ No Date placed?** _____

5. **Do you take aspirin on a daily basis? ☐ Yes ☐ No** **NOTE: Aspirin is a medication. Taking aspirin on a daily basis can affect possible surgical treatment.**

6. **Are you a smoker? ☐ Yes ☐ No Approximately, how much?** _____

7. **Have you ever taken any of the diet medications known as Fen-Phen, or Redux? ☐ Yes ☐ No**
   If yes, was a heart problem diagnosed after using this medication? ☐ Yes ☐ No

8. **Have you taken Cortisone within the past year? ☐ Yes ☐ No When and how long?** _____

Do You Have or Have You Ever Had: (*check those which apply*)

___Heart problems	___Cancer	___Diabetes	___Stomach trouble/Intestinal
___High blood pressure	___Liver disease	___Kidney or bladder trouble	___Arthritis
___Artificial heart valve replace.	___Hepatitis	___Prolonged bleeding	___Psychological problems
___Joint replacement	___Jaundice (Yellow skin)	___Thyroid trouble	___Alcoholism or Drug addiction
___Rheumatic Fever	___Stroke	___Asthma	___Other
___Heart Murmur	___Tuberculosis	___HIV+	
___Anemia	___Lung Trouble	___Glaucoma	
___Bacterial endocarditis	___Pain in chest	___Fainting or Dizziness	
	___Shortness of breath	___Epilepsy or Convulsions	

What medications are you taking or have you taken in the past year? _____

_____

Please describe any current medical treatment, impending operations, or any other medical or dental information that may affect your periodontal care.

WOMEN

1. **Are you pregnant?** ☐ **Yes** ☐ **No**
2. **Are you presently taking birth control pills?** ☐ **Yes** ☐ **No** **Hormones?** ☐ **Yes** ☐ **No**
3. **Have you reached menopause?** ☐ **Yes** ☐ **No**

THE FOLLOWING IMPORTANT HISTORY IS NECESSARY FOR YOUR PERIODONTAL DIAGNOSIS AND TREATMENT PLANNING

Who is your regular dentist? _____ **For how long?** _____

When did you last have any dental work? _____

When were your teeth last cleaned? _____

Yes___ No ___	Are you currently experiencing pain from your mouth?
Yes___ No ___	Have you ever had periodontal treatment?
Yes___ No ___	Has periodontal disease been found in your mouth before?
Yes___ No ___	Do you fear dental treatment?
Yes___ No ___	Have you had any teeth extracted recently?
Yes___ No ___	Are you satisfied with the appearance of your teeth?
Yes___ No ___	Would you be tremendously disturbed if you had to lose your teeth and wear false teeth?
Yes___ No ___	Have you noticed any bad oral odors or taste?
Yes___ No ___	Are your teeth sensitive to hot or cold drinks, sweets, chewing or touch?
Yes___ No ___	Does food catch or wedge between your teeth?
Yes___ No ___	Have you noticed bleeding during brushing, flossing, or eating?
Yes___ No ___	Do you have any loose teeth?
Yes___ No ___	Are your gums receding?
Yes___ No ___	Do your teeth come together unevenly?
Yes___ No ___	Do you ever have “tightness” or pain in the jaw joints?
Yes___ No ___	Do you have frequent headaches?
Yes___ No ___	Do you clench or grind your teeth at night or during the day?
Yes___ No ___	Have you noticed your bite changing or any teeth moving?
Yes___ No ___	Have you noticed increasing spaces between your teeth?
Yes___ No ___	How often do you brush your teeth? _____ Floss?_____
Yes___ No ___	Are you using any other dental cleaning aids? What?_____
Yes___ No ___	Have you worn braces on your teeth?

Patient’s Signature _____ **Date** _____

Periodontist’s signature _____ **Date** _____