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Practice Limited to Periodontics

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PATIENT INFORMATION

(THIS INFORMATION IS NECESSARY FOR OUR FILES AND WILL BE CONSIDERED CONFIDENTIAL)

DATE _____

MR.
MRS.
MS.
MISS _____ _____ _____ _____
PATIENT'S LAST NAME | FIRST NAME | MIDDLE IN. | NAME YOU PREFER TO BE CALLED

_____ _____ _____ _____ ( )
CURRENT STREET ADDRESS | CITY | STATE | ZIP | HOME PHONE

_____ ( )
PREVIOUS ADDRESS (IF LESS THAN 3 YEARS AT CURRENT ADDRESS) | CELL PHONE OR PAGER

_____ ( )
OCCUPATION | WORK PHONE

_____ _____
EMPLOYER NAME | FULL ADDRESS OF EMPLOYER

_____ _____ _____ _____
PATIENT'S BIRTHDATE | SOCIAL SECURITY NUMBER | DRIVER'S LICENSE NUMBER | IF A STUDENT, NAME OF SCHOOL/COLLEGE

FINANCIAL INFORMATION

_____ _____
NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT | RELATIONSHIP

_____ _____ _____ _____ ( )
CURRENT STREET ADDRESS IF DIFFERENT FROM ABOVE | CITY | STATE | ZIP | HOME PHONE

INSURANCE INFORMATION

☐ Same as above for ①,②,③ or

① _____ _____
INSURED PERSON'S FULL NAME | BIRTHDATE

② _____ _____ ( )
SOCIAL SECURITY NUMBER | RELATIONSHIP TO PATIENT | WORK PHONE

_____
INSURANCE COMPANY NAME

_____ _____
GROUP OR UNION NAME | GROUP OR LOCAL NUMBER

③ _____ _____
EMPLOYER NAME | FULL ADDRESS OF EMPLOYER

DO YOU HAVE OTHER DENTAL COVERAGE? _____ YES _____ NO (IF YES, COMPLETE THE FOLLOWING)

_____ _____
INSURED PERSON'S FULL NAME | BIRTHDATE

_____ _____ ( )
SOCIAL SECURITY NUMBER | RELATIONSHIP TO PATIENT | WORK PHONE

_____
INSURANCE COMPANY NAME

_____ _____
GROUP OR UNION NAME | GROUP OR LOCAL NUMBER

_____ _____
EMPLOYER NAME | FULL ADDRESS OF EMPLOYER

GENERAL INFORMATION

_____ _____ ( )
SPOUSE'S LAST NAME | SPOUSE'S FIRST NAME | WORK PHONE

_____ _____
OCCUPATION | EMPLOYER NAME

_____
FULL ADDRESS OF EMPLOYER

PLEASE COMPLETE ALL INFORMATION

HEALTH QUESTIONNAIRE

WHEN DID YOU LAST CONSULT A PHYSICIAN? _____

PHYSICIAN'S NAME _____ PHONE _____

PHYSICIAN'S ADDRESS _____

IF KAISER PATIENT KAISER #_____

1. Have you been under the care of a medical doctor during the past two years? ..... YES NO
   If yes, for what? _____
   Physician's Name _____ Phone _____
   Address _____ City _____ State _____ Zip _____
2. Have you taken any medication or drugs during the past two years? ..... YES NO
3. Are you taking any medication, drugs or pills now, including regular dosages of asprin? ..... YES NO
   If yes, please list name and dosage _____
4. Are you now, or have you ever taken medication for the prevention of osteoporosis (bisphosphonates, such as FOSAMAX, ZOMETA, AREDIA, ACTONEL, BONIVA)? ..... YES NO
5. Have you ever taken prescription medications for weight loss (diet pills)? ..... YES NO
   If yes, did you take any of the following:
   Yes No Fen-Phen (Fenfluramine-Phentermine)
   Yes No Pondimen (Fenfluramine)
   Yes No Redux (Dexfenfluramine)
   If yes to any of the above, did you have a medical exam for heart issues? ..... YES NO
6. Are you sensitive/allergic to (or ever had a reaction to) latex, iodine, penicillin, local anesthetics, or other drugs? ..... YES NO
   If yes, please list:_____
7. Have you been a patient in the hospital during the past five years? ..... YES NO
8. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Heart (Surgery, Disease, Attack)	YES	NO	Diabetes	YES	NO	A.I.D.S.	YES	NO
Congenital Heart Disease	YES	NO	Thyroid Problems	YES	NO	H.I.V. Positive	YES	NO
Heart Murmur	YES	NO	Emphysema	YES	NO	Cold Sores/Fever Blisters	YES	NO
High Blood Pressure	YES	NO	Tuberculosis	YES	NO	Hemophilia	YES	NO
Mitral Valve Prolapse	YES	NO	Asthma	YES	NO	Sickle Cell Disease	YES	NO
Artificial Heart Valve	YES	NO	Latex Sensitivity	YES	NO	Liver Disease	YES	NO
Heart Pacemaker	YES	NO	Allergies or Hives	YES	NO	Neurological Disorders	YES	NO
Rheumatic Fever	YES	NO	Sinus Trouble	YES	NO	Epilepsy or Seizures	YES	NO
Stroke	YES	NO	Radiation Therapy	YES	NO	Nervous/Anxious	YES	NO
Artificial Joints (hip, knee, etc.)	YES	NO	Chemotherapy	YES	NO			
Kidney Trouble	YES	NO	Hepatitis A (infectious) B (Serum)	YES	NO			

9. Do you have or have you had any disease, condition, or problem not listed? ..... YES NO
   If yes, please list:_____
10. **Women.** Are you: **Pregnant?** Yes, _____ Months No **Nursing?** Yes No **Taking birth control pills?** Yes No
11. NAME AND ADDRESS OF RELATIVE (OTHER THAN SPOUSE) OR CLOSE FRIEND IN CASE OF EMERGENCY:

_____ PHONE ( ) _____

_____

DENTAL HEALTH INFORMATION

NAME OF REFERRING GENERAL DENTIST _____ CITY _____ HOW LONG HIS/HER PATIENT? _____

1. CHIEF DENTAL COMPLAINT AT THE MOMENT _____

2. HAVE YOU EVER HAD ANY PREVIOUS PERIODONTAL (GUM) TREATMENT? YES NO

   DOCTOR _____ YEAR _____

3. DO YOUR GUMS EVER BLEED WHEN YOU BRUSH YOUR TEETH? YES NO

4. DO YOU SUFFER FROM PAIN AND/OR SWELLING OF YOUR GUMS? YES NO

5. HAVE YOU NOTICED ANY SPREADING APART OF YOUR TEETH? YES NO

6. HAVE YOU NOTICED ANY LOOSENING OF YOUR TEETH? YES NO

7. DO YOU SUFFER FROM PAIN OR SENSITIVITY OF THE JOINTS OF YOUR JAW? YES NO

8. DO YOU HAVE TROUBLE OR DISCOMFORT IN OPENING YOUR JAW WIDE? YES NO

9. DO YOU OFTEN FIND YOURSELF CLENCHING AND/OR GRINDING YOUR TEETH? YES NO

10. HAVE YOU EVER HAD A BAD REACTION TO DENTAL ANESTHETIC? YES NO

11. HAVE YOU EVER HAD COMPLICATIONS FOLLOWING DENTAL SURGERY? YES NO

    IF YES, PLEASE EXPLAIN _____

12. DO YOU SMOKE OR CHEW TOBACCO? YES NO

PERSONAL ORAL HYGIENE

1. HOW OFTEN DO YOU HAVE YOUR TEETH CLEANED BY A DENTIST OR HYGIENIST?

   _____ LAST TIME _____

2. HOW OFTEN DO YOU BRUSH YOUR TEETH? _____

3. DO YOU USE ANYTHING TO CLEAN IN BETWEEN YOUR TEETH? _____

   IF YES, WHAT? _____

FOR ALL PATIENTS

I hereby authorize the doctor to perform any and all forms of treatment, medication, and therapy, that may be indicated in connection with the dental care of the patient above and further authorize and consent that the doctor chooses and employs such assistance as he deems fit. I also understand that previous to treatment, full explanation of the procedure(s) involved will be given by the doctor and/or his staff. I agree to pay for all services rendered by this office.

_____ _____ _____ _____

PATIENT'S SIGNATURE or SIGNATURE OF RESPONSIBLE PARTY RELATIONSHIP DATE