

We'd like to get to know you better...

Please complete this form and bring it with you to your appointment.

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Diplomate American Board of Periodontology
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Diplomate American Board of Periodontology
Practice Limited to Periodontics

Date: _____

Name: _____
Last First Middle Initial

Address: _____
Street City State Zip

Height: _____ Weight: _____ Social Security #: _____ Date of Birth _____

Home Phone: () _____ Business Phone: () _____

Occupation: _____

Referred by: _____ Date of Last Physical Exam: _____

Physician's Name: _____ Physician's Address: _____

In case of an emergency, contact: _____ Phone Number: () _____

Dental Insurance Company _____ EMPLOYEE or SUBSCRIBER

Name: _____
Last First Middle Initial

Address: _____
Street City State Zip

Subscriber's Employer/Company: _____ Subscriber's S.S. #: _____

Address of Employer: _____
Street City State Zip

Phone No: () _____ Group No.: _____ No. of Local: _____

Date Coverage Effective: _____ Date Coverage Terminated: _____ Date of Birth _____

Secondary Dental Insurance Company _____ EMPLOYEE or SUBSCRIBER

Name: _____
Last First Middle Initial

Address: _____
Street City State Zip

Subscriber's Employer/Company: _____ Subscriber's S.S. #: _____

Address of Employer: _____
Street City State Zip

Phone No: () _____ Group No.: _____ No. of Local: _____

Date Coverage Effective: _____ Date Coverage Terminated: _____ Date of Birth _____

Medical Insurance Company _____ EMPLOYEE or SUBSCRIBER

Name: _____
Last First Middle Initial

Address: _____
Street City State Zip

Subscriber's Employer/Company: _____ Subscriber's S.S. #: _____

Address of Employer: _____
Street City State Zip

Phone No: () _____ Group No.: _____ No. of Local: _____

Date Coverage Effective: _____ Date Coverage Terminated: _____ Date of Birth _____

Dental History

What is your present dental problem: _____

Are you having any discomfort or pain?	YES	NO	If so, where?	_____	
Are your teeth sensitive to cold, hot, sweets?	YES	NO	Do you clench or grind your teeth?	YES NO	
Do your jaws ache when you awaken?	YES	NO	Do you feel that you chew satisfactorily?	YES NO	
Are you satisfied with your teeth's appearance?	YES	NO	Have you had orthodontic therapy (braces)?	YES NO	
Have you had prior periodontal therapy?	YES	NO	How often do you brush your teeth?	_____	
Circle any of the following used regularly:	rubber tip	toothpicks	stimulents	dental floss	water pik

Medical History

Are you now or have you been in the last five years under the care of a physician? _____ YES NO
 If yes, for what? _____

Have you ever had any serious illness? _____ YES NO
 If yes, explain: _____

Are you taking any medications (vitamins, medicines, or drugs) at the present time? _____ YES NO
 If yes, list: _____ Aspirin? _____ YES NO
 For what purpose? _____

Is there any medication you cannot take because you are allergic to it or because it makes you sick? _____ YES NO

Are you allergic to penicillin?	YES	NO	Are you allergic to latex?	YES	NO
Have you ever had a local anesthetic?	YES	NO	Any adverse reaction? _____	YES	NO

Have you ever had or been treated for:

Heart Disease	YES	NO	Heart Murmur	YES	NO
Rheumatic Fever	YES	NO	Asthma or Hay Fever	YES	NO
Abnormal Blood Pressure	YES	NO	Sinus Trouble	YES	NO
Ulcers	YES	NO	Tuberculosis or Lung Disease	YES	NO
Hepatitis	YES	NO	Jaundice	YES	NO
Diabetes	YES	NO	Arthritis	YES	NO
Epilepsy	YES	NO	Stroke	YES	NO
Anemia	YES	NO	AIDS	YES	NO
Congenital Heart Disease	YES	NO	Nervous Disorders	YES	NO
Blood Disorders	YES	NO	Venereal Disease	YES	NO
Thyroid	YES	NO	Kidney or Liver Involvement	YES	NO

Have you ever had abnormal bleeding following a cut or dental extraction? _____ YES NO

Have you ever had radiation or X-ray treatments for any disease? _____ YES NO

Have you ever fainted? YES NO Do you have frequent and severe headaches? _____ YES NO

Do you have chronic sores or boils of any kind on your skin? _____ YES NO

Did any of your blood relatives have diabetes? _____ YES NO

Do you smoke? YES NO How much? _____ Alcohol? _____

Do you get short of breath after climbing one flight of stairs? _____ YES NO

Do you sleep on two or more pillows at night? _____ YES NO

Do your ankles swell during the day? _____ YES NO

Do you ever get pains in your chest or over your heart? _____ YES NO

Any unusual dietary habits? _____ YES NO

WOMEN ONLY

Are you pregnant?	YES	NO	Are you taking hormones?	YES	NO
How long? _____					
Are you taking birth control pills?	YES	NO	Have you reached menopause?	YES	NO

SIGNATURE _____

DATE _____

B.P. _____