

Name _____	Date of Birth _____
Home Address _____	Home Phone _____
City/Zip _____	Work Phone _____
E-Mail Address _____	Cell Phone _____
Social Security # _____	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married
Occupation _____	Name of Spouse _____
Referred By _____	General Dentist _____
<b>Emergency Contact (Name, Relation, Phone) _____</b>	

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT YOUR GENERAL HEALTH:

1. What is your impression of your general health? \_\_\_\_\_
2. When was the last time you were examined by a physician? \_\_\_\_\_
3. What is your physician's name? \_\_\_\_\_
4. Please circle any of the following which you have had or have now:

AIDS / HIV Positive	Chest Pains	Injury to Face / Jaw
Allergies	Cortisone / ACTH	Kidney Problems
Anemia	Diabetes	Lung Problems
Angina Pectoris	Epilepsy / Seizures	Operations
Arthritis	Fainting / Dizzy Spells	Prolonged Bleeding
Artificial Heart Valve	Heart Disease	Psychiatric Treatment
Artificial Joint	Heart Murmur	Rheumatic Fever
Asthma	Hepatitis	Tuberculosis
Cancer	High Blood Pressure	Ulcer

- Yes or No    have you been under a physician's care within the last year?  
If yes, for what? \_\_\_\_\_
- Yes or No    Are you presently taking any medications?  
If yes, which ones? \_\_\_\_\_
- Yes or No    Are you presently taking any herbal or vitamin supplements?  
If yes, which ones? \_\_\_\_\_
- Yes or No    Are you allergic to any medications or materials?  
If yes, which ones? \_\_\_\_\_
- Yes or No    Have you ever had a reaction to a local anesthetic?
- Yes or No    Have you ever had complications from any dental treatment?
- Yes or No    Do you have any diseases/conditions not listed above?
- Yes or No    Have you ever been told that you were not eligible to give blood?
- Yes or No    Women: Are you pregnant?                      If yes, what trimester? \_\_\_\_\_

Yes or No Are you presently having problems in your mouth or involving your face?  
 If yes, please explain \_\_\_\_\_

Yes or No Do you use tobacco? If yes, how much and what type? \_\_\_\_\_

Yes or No Have you ever had treatment for gum disease?

Yes or No Have you ever had orthodontic treatment? If yes, at what age? \_\_\_\_\_

Periodontal (gum) infections can have several symptoms. Do you have any of the following:

- |  |                                       |   |
|--|---------------------------------------|---|
| <input type="checkbox"/> Bleeding Gums           | <input type="checkbox"/> Swollen Gums | <input type="checkbox"/> Receding Gums          |
| <input type="checkbox"/> Sensitivity to hot/cold | <input type="checkbox"/> Loose Teeth  | <input type="checkbox"/> Halitosis (Bad Breath) |

Periodontal (gum) diseases can have a genetic component.

Yes or No Do any of your relatives (parents, brothers, sisters, children) have periodontal problems?  
 Yes or No Have they complained of any of the above named symptoms?

Certain periodontal bacteria can be transmitted among family members.

Yes or No Have any of your immediate family members been diagnosed with periodontal disease?  
 Yes or No If you have any missing teeth or any teeth can't be saved, are you interested in replacing them with dental implants?

<u>Dental Insurance Information</u>	
Yes or No Do <u>you</u> have dental insurance?	Yes or No Does <u>your spouse</u> have dental insurance?
Employer Name _____	Employer Name _____
Employer Address _____	Employer Address _____
City/Zip _____	City/Zip _____
Insurance Name _____	Insurance Name _____
Insurance Address _____	Insurance Address _____
Insurance City/State/Zip _____	Insurance City/State/Zip _____
Insurance Phone _____	Insurance Phone _____
Group Number _____	Group Number _____
Your Insurance ID# _____	Spouse's SS/ID _____
	Spouse's DOB _____
Have you utilized your dental insurance for other dental work this calendar year? Yes ___ No ___	
If yes, what treatment was provided and by whom? _____	

Additional Comments: \_\_\_\_\_

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_  
 (If patient is unable to sign or is a minor, then signature of parent or legal guardian.)