

TREASURE VALLEY PERIODONTICS & IMPLANT DENTISTRY
813 N. STILSON ROAD, SUITE C - BOISE, IDAHO 83703
(208) 344-0908

Name (<i>First, M, Last</i>):			Preferred Name:		
Address:		City:		Zip:	
Home Phone:	Cell:	Work Phone:		DOB:	
Preferred number to reach you (please circle): Home Work or Cell			Referred By:		
Employer:			Occupation:		
Name of Spouse/Parent:			E-mail:		
Spouse's/Parent's Employer:			Occupation:		
Dentist:		Physician:		Pharmacy:	
Primary Dental Insurance:		Subscriber Name/#:		DOB:	
Secondary Dental Insurance:		Subscriber Name/#:		DOB:	

ASSIGNMENT AND RELEASE OF INFORMATION

I hereby authorize my insurance benefits to be paid directly to the dentist and I am financially responsible for services not insured. I further authorize the dentist to release any medical or dental information requested by my insurance company.

SIGNED: _____ DATE: _____

DENTAL HISTORY

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

1. Are you having pain or discomfort at this time?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Do you feel nervous about having dental treatment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Is there anything we can do to make you more comfortable? _____		
4. Have you experienced unfavorable reaction from previous dental treatment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. How often do you have your teeth cleaned? _____ Last Cleaning Date: _____		
6. How often do you brush your teeth? _____ times per day. How often do you floss? _____ times per day.		
7. Do your gums bleed? How often? Daily _____ Sometimes _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8. Are you dissatisfied with the appearance of your teeth?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
9. Have you noticed any loose teeth?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
10. Have any of your teeth recently separated, creating space between them?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
11. Does food wedge between any of your teeth?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
12. Does your jaw click when you chew?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
13. Do you clench or grind your teeth?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
14. Have you ever worn a bite splint or used a CPAP machine? (please circle)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
15. Is it difficult to open your mouth wide?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
16. Do you ever have pain in the region in front of your ears?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
17. Have you been under increased stress lately?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
18. Do you have frequent canker or cold sores?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
19. Have you ever had an injury to your face? What / When? _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
20. Have you ever received periodontal (gum) treatment? What / When? _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
21. Have you ever been sedated for a medical or dental procedure? Any Complications? Yes / No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
22. Is there a history of periodontal disease in your family?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
23. Do either of your parents wear dentures?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
24. Do you smoke or use smokeless tobacco? Y / N Amount per day _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
25. Have you ever tried to quit tobacco? Year? _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
26. Are you in or have you ever been in a substance abuse or recovery program?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
27. Are you pregnant, possibly pregnant or nursing (please circle)	<input type="checkbox"/> Yes	<input type="checkbox"/> No

MEDICAL HISTORY

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

1. Are you in good health? Last date of Physical Examination: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Have you been under the care of a medical doctor during the past two (2) years? For what? _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Are you taking any prescription, over the counter or herbal medications? Please List: _____ _____ _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Are you allergic to or have you reacted adversely to any of the following? <input type="checkbox"/> Local Dental Anesthetic <input type="checkbox"/> Aspirin <input type="checkbox"/> Latex <input type="checkbox"/> Penicillin <input type="checkbox"/> Codeine(Rash or Nausea) circle one <input type="checkbox"/> Metals/Jewelry (please circle) <input type="checkbox"/> Sulfa <input type="checkbox"/> Ibuprofen <input type="checkbox"/> Other (please list) _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. Do you have or have you ever had any of the following? <input type="checkbox"/> Heart Disease <input type="checkbox"/> Glaucoma – is this narrow angle? Yes / No <input type="checkbox"/> Heart Attack <input type="checkbox"/> Bypass <input type="checkbox"/> Pacemaker <input type="checkbox"/> Hepatitis or Liver Disease Date: _____ <input type="checkbox"/> Arthritis <input type="checkbox"/> Artificial Heart Valve <input type="checkbox"/> Heart Stent <input type="checkbox"/> Ulcers Date: _____ <input type="checkbox"/> Kidney or <input type="checkbox"/> Bladder Trouble <input type="checkbox"/> Congenital Heart Defect _____ <input type="checkbox"/> Venereal Disease Is premedication necessary? Yes / No <input type="checkbox"/> HIV or <input type="checkbox"/> Aids Date Diagnosed: _____ <input type="checkbox"/> Autoimmune disease <input type="checkbox"/> Asthma <input type="checkbox"/> Lupus <input type="checkbox"/> Fibromyalgia or <input type="checkbox"/> Other: _____ <input type="checkbox"/> Blood Disorder such as Anemia <input type="checkbox"/> Artificial Joints Type: _____ Date: _____ <input type="checkbox"/> Psychiatric treatment <input type="checkbox"/> Stroke Date: _____ <input type="checkbox"/> Frequent or severe headaches <input type="checkbox"/> High or <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> Prednisone, Cortisone, or Hydrocortisone (please circle) <input type="checkbox"/> Blood transfusion Date: _____ <input type="checkbox"/> Cancer Type: _____ <input type="checkbox"/> Seasonal Allergies or Sinus Problems <input type="checkbox"/> Radiation Treatment Area: _____ Date: _____ <input type="checkbox"/> History of Bacterial Endocarditis <input type="checkbox"/> Chemo Therapy Date: _____ <input type="checkbox"/> Angina <input type="checkbox"/> Epilepsy or Seizures <input type="checkbox"/> Hypothyroid or <input type="checkbox"/> Hyperthyroid	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6. Is there any history of diabetes in your family?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7. Do you have diabetes? Type I or Type II (circle one) A1C# _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8. Do you take aspirin or another blood thinner daily? If yes, what type? _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
9. Have you ever been treated for or are you currently being treated for Osteoporosis / Osteopenia?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
10. Have you been treated with Bisphosphonate drugs? Please check which ones: <input type="checkbox"/> Actonel <input type="checkbox"/> Aredia <input type="checkbox"/> Boniva <input type="checkbox"/> Didronel <input type="checkbox"/> Fosamax <input type="checkbox"/> Reclast <input type="checkbox"/> Skelid <input type="checkbox"/> Zometa Start Date: _____ End Date: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
11. Is there any health information, which was not asked, which you feel may influence dental treatment? Tell us _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No

CONSENT

This information is held in confidence and used only to assist in treatment. Treatment will not be denied on the basis of medical condition. The undersigned hereby authorize the Doctor and staff to take radiographs, photographs, or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of the patient's dental needs.

	Signature	Date		Signature	Date
	<input type="checkbox"/> No Change		<input type="checkbox"/> No Change		
	Signature	Date		Signature	Date
	<input type="checkbox"/> No Change		<input type="checkbox"/> No Change		
	Signature	Date		Signature	Date
	<input type="checkbox"/> No Change		<input type="checkbox"/> No Change		