Spring | PERIODONTICS AND IMPLANT DENTISTRY

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NAME: _____ **DATE:** _____

ADDRESS: _____
STREET CITY STATE ZIP

SSN: _____ **HOME PHONE: (** ____ **)** _____

DATE OF BIRTH: _____ **AGE:** _____ **SEX:** _____ **HEIGHT:** _____ **WEIGHT:** _____ **EMAIL:** _____

SINGLE: _____ **MARRIED:** _____ **DIVORCED:** _____ **WIDOWED:** _____ **CHILD:** _____

EMPLOYER: _____ **OFFICE PHONE: (** ____ **)** _____

POSITION: _____ **#YRS:** _____ **CELL PHONE: (** ____ **)** _____

SPOUSE/PARENT: _____ **PHONE: (** ____ **)** _____

RESPONSIBLE PARTY: _____ **PHONE: (** ____ **)** _____

***I UNDERSTAND THAT ALL FEES INCURRED WILL BE MY RESPONSIBILITY:** _____
SIGNATURE

REFERRED TO THIS OFFICE BY:

FAMILY DENTIST: _____ **LOCATION:** _____ **PH #:** _____

FAMILY PHYSICIAN: _____ **LOCATION:** _____ **PH #:** _____

Are you experiencing pain in your mouth now	YES	NO
Have you had previous periodontal (gum) care	YES	NO
Do you have your teeth cleaned on a regular basis	YES	NO
Do you brush your teeth regularly (2-3 times per day)	YES	NO
Have I treated your friends or family	YES	NO
Do you smoke	YES	NO
Have you ever smoked	YES	NO

BRIEFLY OUTLINE WHAT YOU MIGHT HAVE FOR:

BREAKFAST: _____ ALCOHOL INTAKE: Drinks/Day: _____

LUNCH: _____ COFFEE/Day: Reg. _____ Decaf _____

DINNER: _____ SOFT DRINKS/Day: _____

DAILY EXERCISE: _____ HOURS OF SLEEP/Night: _____

Have you had swollen areas of the gums	YES	NO
Do your gums bleed	YES	NO
Have yo unoticed any loose teeth	YES	NO
Have you noticed any bad odors or tastes	YES	NO
Are your teeth sensitive to hot, cold, or sweets	YES	NO
Have your front teeth separated, causing spaces	YES	NO
Do you floss or use gum stimulators on a daily basis	YES	NO
Have you ever worn braces to straighten your teeth	YES	NO
Would you be disturbed if you had to wear false teeth	YES	NO
Are you aware of any clenching/griding of teeth at night	YES	NO
Do you have headaches on a regular basis	YES	NO
Have you ever had a frightening experience with dentistry	YES	NO

PLEASE CHECK ANY OF THE FOLLOWING YOU EVER HAD:

_____ Allergies to drugs
_____ AIDS
_____ AIDS Related Complex
_____ HIV Antibody Positive
_____ Asthma
_____ High Blood Pressure
_____ Cancer
_____ Cardiac Problems
_____ Chest Pains
_____ Shortness of Breath
_____ Heart Attack
_____ Stroke
_____ Cold Sores
_____ Fever Blisters
_____ Chronic Cough
_____ Diabetes
_____ Epilepsy
_____ Excessive Bleeding
_____ Fainting
_____ Frequent Thirst
_____ Gonorrhea
_____ Hay Fever
_____ Hepatitis
_____ Herpes (Mouth)
_____ Herpes (Genital)
_____ Hives Rash
_____ Jaundice
_____ Kidney Disease
_____ Liver Disease
_____ Mitral Valve Prolapse
_____ Mononucleosis
_____ Pneumonia
_____ Psychiatric Treatmetn
_____ Radiation Treatment
_____ Rheumatic Fever
_____ Scarlet Fever
_____ Seizures
_____ Sinus Problems
_____ Syphilis
_____ Thrush
_____ Trench Mouth
_____ Tuberculosis
_____ Tonsils Removed
_____ Sudden Weight Loss

ARE YOU OR HAVE YOU EVER TAKEN ANY OF THE FOLLOWING DRUGS:

Cortisone Drugs, Steroids or ACTH..... YES NO
Anticoagulants or Blood Thinners..... YES NO
Tranquilizers or Sedatives..... YES NO
Do you have any blood disorders such as anemia..... YES NO

Please list any medications you are currently taking: _____

ALLERGIES:
ARE YOU ALLERGIC TO OR HAVE YOU EVER REACTED ADVERSELY TO:

Local Anesthetics..... YES NO
Penicillin or other antibiotics..... YES NO
Sulfa drugs..... YES NO
Barbiturates..... YES NO
Aspirin..... YES NO
Iodine..... YES NO
Codeine or other narcotics..... YES NO
OTHER..... YES NO
Do you take an antibiotic prior to any dental or medical treatment..... YES NO

PARENTS HISTORY:

Mother:	Teeth Present	Gum Disease	Dentures
Father:	Teeth Present	Gum Disease	Dentures

WOMEN ONLY:

Are you pregnant?_____
No. of children:_____
Birth weights:_____

WHAT IS THE CHIEF COMPLAINT ABOUT YOUR MOUTH OR TEETH? _____

_____

_____

FOR OFFICE USE ONLY

PRE-MED_____ ACHROMYCIN _____
NaBUTISOL_____ VICODEN_____
DEMEROL_____ OTHER_____
PHENERGAN_____ MEDICAL CONSULT_____
N_2O_2 _____
OTHER_____