

HEALTH HISTORY AND REGISTRATION

Date _____ Birthdate _____
 Name _____ Home Phone _____
 Home Address _____ City _____ Zip _____
 Social Security Number _____ Driver's License Number _____
 Place of Employment _____ Occupation _____
 Work Phone _____ Cell Phone _____ E-Mail _____
 Name of Spouse (Parent if a minor) _____ SSN _____ DOB _____
 Place of Employment for spouse _____
 Name and Telephone of Person to Contact in Case of Emergency _____
 Name of Dental Insurance Company _____ Insured _____
 Who Referred you to our office? _____

MEDICAL HISTORY

Periodontal disease is influenced by a combination of factors. Successful treatment depends on their identification. The following questions are pertinent to the diagnosis and treatment of your periodontal condition. All information will be held in confidence.

1. Date of last physical examination _____
2. Physician's name _____ Phone _____
 Address _____
3. Do you have any current medical problems? YES/NO
 Specify _____
4. Have you seen a physician within the last year? YES/NO
 Specify _____
5. Have you been seriously ill or hospitalized? YES/NO
 Specify _____
6. Are you taking any drugs, medications or injections? Including over the counter & daily aspirin YES/NO
 Specify _____
7. Have you had or been exposed to any of the following? YES/NO
 _____ Hepatitis _____ AIDS or HIV virus
 _____ Tuberculosis _____ Venereal Disease _____ Other _____
8. Please indicate if you have had any of the following:

___ rheumatic heart condition	___ heart murmur	___ angina
___ prolapsed mitral valve	___ heart palpitations	___ glaucoma
___ prosthetic heart value	___ fainting or dizziness	___ diabetes
___ open heart or bypass surgery	___ pacemaker	___ epilepsy
___ chest pains on exertion	___ heart attack	___ arthritis
___ high or low blood pressure	___ liver disorder	___ ulcer
___ frequent headaches	___ kidney disorder	___ osteoporosis
___ periods of depression	___ lung problems	___ anemia
___ convulsions or seizures	___ cancer or tumor	___ other _____
___ alcohol or drug related problem	___ radiation therapy	
9. Have you had abnormal bleeding associated with extractions, surgery, injury, or menstruation? YES/NO
10. Have you ever had a blood transfusion? YES/NO
11. Do you have an implant such as a heart valve or joint replacement? YES/NO
12. Are you allergic to, or have you experienced an adverse reaction to any drug or medication? YES/NO

___ tetracyclines	___ other antibiotics	___ codeine
___ penicillin	___ dental anesthetic	___ aspirin
___ sulfa drugs	___ barbituates	___ other _____
13. Is there a tendency towards any illness in your family?
 ___ diabetes _____ heart trouble _____ other _____
14. Do you smoke? YES/NO Frequency _____
15. Do you drink alcoholic beverages? YES/NO Frequency _____

(OVER)

16. Are you under any unusual stress? YES/NO
 ___ business ___ family ___ financial ___ social
17. Do you have any disease, condition or problems not listed above that I should know about? _____

WOMEN ONLY

18. Are you taking Birth Control Pills? YES/NO
19. Are you pregnant or trying to get pregnant? YES/NO
20. Are you nursing? YES/NO
21. Have you reached menopause? YES/NO

DENTAL HISTORY

1. Who is your regular dentist? _____
2. How long have you been his/her patient? _____
3. What is your immediate dental concern? _____
4. When were your teeth last cleaned? _____
5. What has been your usual interval for dental visits in the past?
 ___ regularly (at least yearly) ___ infrequent (only when in pain) ___ seldom
6. Do you wear full or partial dentures? YES/NO
7. Have you ever had periodontal treatment? YES/NO _____
8. Have you ever had orthodontic treatment? YES/NO _____
9. Have you ever experienced any of the following?
 ___ painful or sore gums ___ swelling of the gums ___ bleeding gums
 ___ bad breath or bad taste ___ drifting of teeth ___ loose teeth
 ___ gum boil or abscess ___ sensitive teeth ___ receding gums
10. How often do you brush your teeth? _____
11. What kind of toothbrush do you use?
 ___ soft ___ medium ___ hard ___ electric
12. Do you use anything else to clean your teeth?
 ___ floss ___ toothpick ___ proxy brush ___ other _____
13. Do you clench or grind your teeth? YES/NO
14. Do you awaken in the morning with sore jaws? YES/NO
15. Do you feel your bite is off? YES/NO
16. Do you have a popping, clicking, grinding or soreness in the joints in front of the ears? YES/NO
17. Do you have a dry mouth or breathe through your mouth rather than your nose? YES/NO
18. Do you eat a well-balanced diet? YES/NO
19. Do you eat many sweets? YES/NO
20. Do you suck on mints or candy regularly? YES/NO
21. Do you drink sugar sweetened drinks often? YES/NO
22. Have you ever had a bad experience in a dental office? YES/NO
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23. Are you apprehensive about dental treatment? YES/NO
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24. Is there anything that concerns you about dental treatment? YES/NO
-
25. Are you happy with the appearance of your teeth? YES/NO
26. Would you like your smile to look better or different? YES/NO
27. Please indicate any of the following that would keep you from having dental treatment:
 ___ fear of pain ___ lack of concern ___ cost of treatment ___ missing work time

These statements are true to the best of my knowledge. I have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices/ I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

PRINT PATIENT NAME: _____

PATIENT SIGNATURE _____ DATE _____

(Parent if child) This signature gives my permission for Dr. Wright and her team to treat my child/myself (circle one)