The following information will make it possible for us to be more successful and thorough in your treatment. Your answers are for our records only and will be considered confidential.

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City State Zip Code

Home/Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gender \_\_\_\_\_\_ Height \_\_\_\_\_\_ Weight\_\_\_\_\_\_ Marital Status \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relation:\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_

Employer’s Name and Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Business Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Physical Examination Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Dentist \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Last Dental Treatment \_\_\_\_\_\_\_\_\_\_\_\_\_\_ What was done? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who may we thank for referring you to this office? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Give your reason(s) for seeking periodontal treatment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dental Insurance Information**:

Subscriber’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber’s Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber’s Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber’s SS Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Company Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Member ID Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance Group Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Secondary Dental Insurance Information**:

Subscriber’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber’s Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber’s Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber’s SS Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Company Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Member ID Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance Group Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical History**

Yes No Are you now under the regular care of a physician?

If so, for what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes No Have you had any major operations, hospitalizations or illnesses?

If so, for what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes No Are you taking any pills, medication or drugs?

If so, please list. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had a reaction to any of the following: (PLEASE CHECK all that apply)

\_\_\_\_ Penicillin \_\_\_\_ Sleeping pills (barbiturates)

\_\_\_\_ Sulfa drugs \_\_\_\_ Tetracycline

\_\_\_\_ Codeine \_\_\_\_ Dental anesthetic (Novocain)

\_\_\_\_ Aspirin \_\_\_\_ Nitrous oxide (laughing gas)

\_\_\_\_ Bisphosphonates \_\_\_\_ Latex

Other allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes No Are you taking bisphosphonates? *(ie: Fosamax, Boniva, Reclast) \_*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes No Are you taking any blood thinners? (*ie: Coumadin/Plavix),* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes No Are you taking any vitamins or herbal medications? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes No Do you smoke? How much:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How Often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes No Do you drink alcohol? How much:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How Often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes No Have you ever had any problems with surgery or anesthesia?

Do you have or have you ever had any of the following: (PLEASE CHECK all that apply)

\_\_\_\_ Rheumatic fever \_\_\_\_

\_\_\_\_ Heart murmur/mitral valve prolapse \_\_\_\_ Ulcers (stomach or duodenal)

\_\_\_\_ Heart attack \_\_\_\_ Kidney or bladder trouble

\_\_\_\_ Arteriosclerosis \_\_\_\_ High or low blood pressure

\_\_\_\_ Diabetes \_\_\_\_ Thyroid disease

\_\_\_\_ Stroke \_\_\_\_ Back problems

\_\_\_\_ AIDS/HIV+ \_\_\_\_ Asthma or difficulty breathing \_\_\_\_ Anemia/blood disorder/Hemophilia \_\_\_\_ Herpes

\_\_\_\_ Tumors or growths \_\_\_\_ Chemical dependency

\_\_\_\_ Radiation therapy/Chemotherapy \_\_\_\_ Arthritis or rheumatism

\_\_\_\_ Artifical heart valves \_\_\_\_ Painful or swollen joints

\_\_\_\_ Frequent headaches \_\_\_\_ Food allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ Jaw pain \_\_\_\_ Rashes or skin disorders

\_\_\_\_ Artificial joints \_\_\_\_ Dizziness or light headedness

\_\_\_\_ Psychiatric care \_\_\_\_ Sinus problems

\_\_\_\_ Frequent fractures or dislocations \_\_\_\_ Depression

\_\_\_\_ Osteoporosis \_\_\_\_ Sexually related disease

\_\_\_\_ Condition requiring cortisone/steroids \_\_\_\_ Pregnant \_\_\_\_ Epilepsy, seizures, convulsions, fainting spells

\_\_\_\_ Hepatitis, jaundice, or other liver disease \_\_\_\_ Birth Control Medication

\_\_\_\_ Shortness of breath or chest pains \_\_\_\_ Cancer

upon exertion \_\_\_\_ Tuberculosis, COPD, emphysema,

or other lung disease

Do you have any disease, condition, or problem not listed above that you think we should be aware of? If so, please explain:

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dental History**

Yes No Are you currently experiencing dental pain? For how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes No Do you consider yourself in good dental health?

Yes No Do you think that your teeth are affecting your health in any way?

Yes No Are you dissatisfied with the appearance of your teeth?

Yes No Are you dissatisfied with your chewing ability?

Have you ever had:

\_\_\_\_ Orthodontic treatment (braces) \_\_\_\_ Periodontal/gum treatment

\_\_\_\_ Oral surgery (extraction, etc.) \_\_\_\_ Your teeth ground or bite adjusted

\_\_\_\_ Night guard/bite plane or any other appliance

Yes No Have you noticed any loosening of your teeth?

Yes No Does food tend to become caught between your teeth?

Yes No Do you suffer from pain and/or swelling of your gums?

Yes No Do your gums often bleed when you brush your teeth?

Yes No Do you have any unpleasant odor or taste in your mouth?

Yes No Are you missing any teeth?

Reasons: Decay ( ) Gum disease ( ) Other ( )\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes No Did either your mother or father lose all her/his natural teeth?

Yes No Sensitivity to ( ) Cold ( ) Hot ( ) Sweets

Yes No Do you ever have any soreness, pain, clicking or popping in the area in front of your ears?

Do you:

\_\_\_\_ Clench or grind your teeth while awake or asleep?

\_\_\_\_ Bite your lips or cheeks regularly?

\_\_\_\_ Hold foreign objects with your teeth?

\_\_\_\_ Breathe primarily through your mouth?

When did you last have your teeth cleaned before this appointment? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often and when do you brush your teeth? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use: Hand toothbrush ( ) Electric toothbrush ( )

Is your toothbrush: Soft ( ) Medium ( ) Hard ( )

What else do you use to clean your teeth? (floss, toothpick, Waterpik, etc.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes No Do you feel apprehensive when you are having a dental treatment?

Yes No Would you like to use nitrous oxide (laughing gas)?

Yes No Does the fear of pain make you postpone your dental treatment?

Yes No Is it important to you to keep your teeth

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change, I will inform the doctor. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all changes whether or not paid by insurance.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_