

FOR OFFICE USE ONLY

PATIENT INFORMATION

Name _____ Preferred Name _____ Date of Birth _____
Address _____ City _____ State _____ Zip _____
SS# _____ Home Phone _____ Cell _____
Driver's License# _____ Email _____
Occupation _____ Work Phone _____ Ext. _____
Employer _____ Employer Address _____
Spouse's Name _____ Spouse's Work Phone _____
Employer _____ Employer Address _____
Emergency Contact _____ Phone _____ Relationship _____
Who referred you to our office? _____

General Dentist _____ No. of years _____ Phone _____

IF YOU HAVE DENTAL INSURANCE, PLEASE COMPLETE THE FOLLOWING (IF TWO POLICIES, COMPLETE BOTH PORTIONS)

Insured Person _____ D.O.B. _____	Insured Person _____ D.O.B. _____
ID # _____ Group # _____	ID # _____ Group # _____
Name of Insurance Co. _____	Name of Insurance Co. _____
Ins. Address _____ Phone _____	Ins. Address _____ Phone _____
City/State/Zip _____	City/State/Zip _____

MEDICAL HEALTH HISTORY

Periodontal disease is caused by a combination of complex factors and successful treatment depends upon their identification. The following questions are pertinent to the treatment of your periodontal condition. Please answer all questions. Circle yes or no, whichever applies. All answers are confidential.

1. How is your general health? _____
2. Date of last physical examination _____ Height _____ Weight _____
3. Physician's name _____ Specialty _____
Address and Telephone _____
4. Are you being treated by a ☐ physician, or a ☐ psychiatrist now? Yes ☐ No ☐
5. Have you ever been ☐ seriously ill, or ☐ hospitalized? Yes ☐ No ☐
If so, explain _____
6. Have you had a transfusion? Yes ☐ No ☐
7. Are you taking any drugs or **medication**? If yes, please check the appropriate box..... Yes ☐ No ☐

☐ antibiotics	☐ anticoagulants (blood thinners)	☐ antidepressants/antianxiety
☐ diabetes medicine	☐ blood-pressure medicine	☐ cortisone (steroids)
☐ hormones	☐ heart medicine	☐ osteoporosis medicine
☐ aspirin	☐ birth control pills	☐ other _____

List all prescriptions and medications: _____

8. Do you have or have you had any of the following? Yes ☐ No ☐

☐ rheumatic heart condition	☐ shortness of breath	☐ periods of depression	☐ thyroid problem
☐ heart palpitations	☐ heart trouble	☐ liver disorder	☐ epilepsy
☐ high/low blood pressure	☐ heart surgery	☐ lung problems	☐ ulcer
☐ heart murmur	☐ prolapsed mitral valve	☐ asthma	☐ stroke
☐ heart attack	☐ frequent headaches	☐ cancer or tumor	☐ arthritis
☐ congenital heart lesion	☐ fainting or dizziness	☐ diabetes	☐ anemia
☐ chest pain on exertion	☐ anxiety	☐ jaundice	☐ glaucoma
☐ other _____			
9. Have you had radiation treatment or chemotherapy? Yes ☐ No ☐
10. Have you ever had a serious infectious disease? Yes ☐ No ☐

☐ Hepatitis	☐ Tuberculosis	☐ Venereal Disease	☐ Herpes	☐ AIDS	☐ other _____
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PLEASE COMPLETE REVERSE SIDE

11. Have you had abnormal bleeding associated with extractions, surgery, or menstruation? Yes ☐ No ☐
12. Do you have a cardiac pacemaker, prosthetic heart valve or prosthetic joint? Yes ☐ No ☐
What do you have? _____
13. Are you **allergic** or have you experienced an unusual reaction to any drugs? Yes ☐ No ☐
☐ dental anesthetic ☐ penicillin ☐ Valium
☐ codeine ☐ erythromycin ☐ Demerol
☐ aspirin ☐ tetracycline ☐ barbituates or sedatives
☐ latex ☐ sulfa ☐ other _____
☐ metals
14. Do you use tobacco/vape? Yes ☐ No ☐
If so, how much per day? _____
15. Do you drink alcohol? Yes ☐ No ☐
If so, how many servings per week? _____
16. Is there a tendency towards any illness in your family? Yes ☐ No ☐
☐ diabetes ☐ heart trouble ☐ other _____
17. Do you have any disease, condition, or problem not listed that I should know about? Yes ☐ No ☐
If so, please list: _____
18. Women: Are you pregnant? Yes ☐ No ☐

DENTAL HEALTH HISTORY

1. Why are you visiting our office? _____

2. Has your dental care been:
☐ regular (yearly) ☐ intermittent (when necessary) ☐ infrequent (when in pain)
3. How many cleaning appointments have you had in the last 5 years? _____
4. Have you ever had Periodontal care? Yes ☐ or No ☐ When _____
 Orthodontic care? Yes ☐ or No ☐ When _____
5. Are you dissatisfied with the appearance of your teeth? Yes ☐ No ☐
6. Have you ever experienced any of the following? Yes ☐ No ☐
☐ bleeding gums ☐ pus around the teeth ☐ foul odor
☐ swelling of gums ☐ loose teeth ☐ bad breath or bad taste
☐ pain or soreness in gums ☐ spaces between teeth ☐ food packing between teeth
☐ receding gums ☐ drifting of teeth ☐ high or rough fillings
7. Are your teeth sensitive? Yes ☐ No ☐
If so, to what? _____
8. Do you grind or clench your teeth? Yes ☐ No ☐
9. Have you ever had an injury to your face, neck, or jaws? Yes ☐ No ☐
10. Do you suffer from pain in the face, neck, or jaws? Yes ☐ No ☐
11. Are you having pain in your mouth now? Yes ☐ No ☐
12. These statements are true and complete to the best of my knowledge Yes ☐ No ☐

THIS NOTICE BELOW DESCRIBES HOW YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect February 20, 2026, and will remain in effect until we replace it. You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of the notice, please let us know at your initial appointment.

Signature of Patient

Date

Signature of Doctor

Date

Please be advised that 24 hours' notice of inability to keep your appointment is expected. Otherwise, reasonable fees for time lost will be charged. In addition, we advise all patients to visit a general dentist for decay examinations annually.

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