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 NORTHERN VIRGINIA PERIODONTICS

PATIENT INFORMATION FORM

(The following information is strictly confidential)

Date _____

Why are you now seeking periodontal treatment? _____

Dr., Mr., Mrs., Miss, Ms. Name: _____ Age _____
 Birth Date _____ Marital Status _____ Home Phone () _____
 E-mail _____ Cell Phone () _____
 Address _____ City _____ ZIP _____
 Occupation _____ Employed By _____ Phone () _____
 Name of Spouse _____ Occupation _____ Employed By _____
 Name of Dentist _____ How Long? _____
 Name of Physician _____ How Long? _____ Phone () _____
 Whom may we thank for referring you? _____
 Name of Dental Insurance Carrier (if any) _____
 Patient's SS# _____ Insured SS# _____ Insured Birth Date _____
 In case of emergency please notify _____ Phone () _____

MEDICAL HISTORY

Height _____ Weight _____ How is your general health? _____
 Date of last physical _____ Are you under active medical care? _____
 If so, for what? _____

Please check the correct response:

- (1) Have there been any changes in your general health recently? No Yes
- (2) Have you lost or gained an excessive amount of weight recently? No Yes
- (3) Have you been seriously ill within the last year? No Yes
- (4) Have you had surgery (an operation) within the last year? No Yes
- (5) Have you been treated for a growth or tumor? No Yes
- (6) Have you ever had excessive bleeding requiring treatment? No Yes
- (7) Have you experienced chest pain or shortness of breath going up a flight of stairs? No Yes
- (8) Have you noticed an increase in frequency of urination? No Yes
- (9) Have you noticed an increase in thirstiness? No Yes
- (10) Please check any of the following which you have had: **NONE OF THE BELOW**

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Steroid Treatments | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Skin Disease |
| <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Asthma/Emphysema | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Fainting/Dizziness |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Hepatitis A |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Stroke | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Hepatitis B or C |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Family History of Diabetes | <input type="checkbox"/> Kidney Disorder | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Heart Pacemaker | <input type="checkbox"/> Venereal Disease (Herpes, Gonorrhea, Syphilis) | | |
| <input type="checkbox"/> Other _____ | | | |

OVER

Please check the correct response:

- (11) Have you ever or are presently undergoing psychiatric care? No Yes
(12) Have you ever experienced an unusual reaction to dental local anesthesia (Novocaine)? No Yes
(13) Are you allergic to any drugs? No Yes
If yes, please indicate: Penicillin Aspirin Codeine
Other _____
(14) Are you presently taking any medications and have you taken any during the last year? No Yes
If yes, please list: _____
(15) Have you taken a drug from the bisphosphonate drug class (fosamax, actonel, boniva...)? No Yes
If yes, what drug and for how long? _____ Are you still taking the drug? No Yes
When did you stop? _____
(16) Do you "premedicate" with antibiotics prior to dental treatment? No Yes
(17) Do you take aspirin or nonsteroidal anti-inflammatories (like Advil) on a daily basis? No Yes
(18) WOMEN Are you pregnant at this time? No Yes
(19) WOMEN Are you or have you had menopause (change of life)? No Yes
(20) WOMEN Have you had a hysterectomy or ovariectomy? No Yes
(21) WOMEN Do you take birth control pills or have you in the past? No Yes

DENTAL HISTORY

- (22) How often do you go to the dentist? _____ Date of last visit _____
(23) What was done for you at that time? _____
(24) When were your teeth last cleaned? _____
(25) Have you had previous periodontal treatment? No Yes
If yes, describe treatment _____ When _____
(26) Have you had previous orthodontic treatment? No Yes
(27) Have you ever had an injury to your face or jaws? No Yes
(28) Are you satisfied with your dental appearance? No Yes
(29) Have any of your teeth changed position in recent years? No Yes
(30) Do you feel that your teeth bite together properly? No Yes
(31) Do you notice food catching between your teeth frequently? No Yes
(32) How often do you brush you teeth? _____ Hard Medium Soft Brush
(33) Do you use any other oral hygiene devices or materials? No Yes
If yes, what and how often? _____
(34) Do your gums bleed when you brush your teeth? No Yes
(35) Are you aware of bad breath? No Yes
(36) Do you have discomfort in your mouth now? No Yes
(37) Have you had any extensive dental treatment? No Yes
If yes, explain _____
(38) Do you wear upper or lower complete or partial dentures? No Yes
(39) What kind of dental health do you think you are in? _____
(40) Do you have any of the following habits?
Grind teeth Bite lip, cheek, or tongue Clench teeth
Smoke or chew tobacco presently or previously:
How much? _____ For how long? _____ Quit when? _____
(41) Please rank your overall stress level Low Moderate High

Is there any additional information which will help us to help you? _____

This medical/dental history is accurate to the best of my knowledge.

Patient Signature _____ Doctor Signature _____