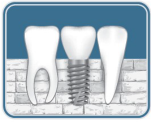

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NORTHERN VIRGINIA PERIODONTICS

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**

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