Periodontic & Implantology Associates

Patient Registration

Date:_____

1. Patient's Last Name _____ 2. First Name _____ 3. M.I. _____
4. Sex: ◯ M ◯ F 5. Marital Status _____ 6. Phones: Home _____ Cell _____ Work _____
6b. E-mail Address: _____
7. Street Address _____ City _____ State _____ Zip _____
8. Patient's Date of Birth _____ 9. Patient's S.S.N. _____ 10. Drivers License # _____
11. Patient Employed By or Retired From _____ 12. Present Position _____
13. Do You Have Dental Insurance? ☐ Yes ☐ No 14. Name of Insured _____ 15. Relationship to Insured _____
16. Insured's S.S.N. _____ 17. Name of Dental Insurance Company _____
18. Group # _____ 19. Employer _____ 20. Salaried ☐ Hourly ☐
21. Do You Have Additional Dental Insurance? ☐ Yes ☐ No **If Yes, please complete questions 22-28, If No, Skip to question 29**
22. Name of Insured _____ 23. Insured DOB _____ 24. Relationship to insured _____
25. Insured's S.S.N. _____ 26. Name of Dental Insurance Company _____
27. Group # _____ 28. Employer _____ 29. Salaried ☐ Hourly ☐
30. Do you have Medical Insurance? ☐ Yes ☐ No 31. Emergency Contact (name/number) _____

Medical History

Yes No

☐ ☐ Do you consider your medical health to be good? When did you have your last medical check-up? Date: _____
☐ ☐ Are you taking ANY medications/vitamins, i.e. fish oil, etc. (prescription or non-prescription) regularly? PLEASE LIST; _____
_____
☐ ☐ Do you normally take ANTIBIOTICS prior to denta! treatment?
☐ ☐ Are you being treated by a medical doctor at this time? For what? _____
☐ ☐ Are you on a special diet?
☐ ☐ Have you recently gained or lost a lot of weight?
☐ ☐ Have you ever had an injury to your face or jaw?
☐ ☐ Do you smoke or chew tobacco? How much? _____

Yes No

☐ ☐ Do you consume alcohol? How much? _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

Yes No

☐ ☐ Heart Disease *(heart valve replacement, mitral valve prolapse, bypass surgery, pace-maker, heart murmur, stent, angioplasty, etc.)*
☐ ☐ Valve, Joint, or Hip Replacement
☐ ☐ Blood Pressure: ☐ High ☐ Low
☐ ☐ Bleeding Problems (medications or clotting disorder)
☐ ☐ Blood Disease (anemia, lukemia, sickle cell)
☐ ☐ Infectious Hepatitis
☐ ☐ Rheumatic Fever
☐ ☐ Osteoporosis (Bisphosphonate Use - ie. Fosamax, Boniva, Prolia)

Yes No

☐ ☐ Cancer
☐ ☐ Radiation Treatments
☐ ☐ Diabetes
☐ ☐ Lung Disease - *TB, COPD Asthma, Emphysema, etc.*
☐ ☐ Kidney Disease
☐ ☐ Liver Disease
☐ ☐ Epilepsy
☐ ☐ Ulcers

Yes No

☐ ☐ Arthritis
☐ ☐ Sinus Trouble
☐ ☐ Glaucoma
☐ ☐ Psychiatric Treatment
☐ ☐ Venereal Disease
☐ ☐ AIDS or HiV+(positive)
☐ ☐ Herpes
☐ ☐ Are you pregnant?
☐ ☐ Do you take oral contraceptives?

☐ ☐ Are you allergic to or react to any medicines or drugs (penicillin, aspirin, novocaine, etc.)? If yes, please explain:
_____
☐ ☐ Do you have multiple allergies (LATEX, foods, etc.)? _____
☐ ☐ Have you ever had painful or swollen joints?
☐ ☐ Do you use recreational drugs (cocaine, marijuana, etc)?
☐ ☐ Do you ever have convulsions or seizures?
☐ ☐ Are you ever short of breath on mild exertion?
☐ ☐ Does anyone in your family have a history of sugar diabetes?
☐ ☐ Have you been hospitalized recently? WHY? _____ WHEN? _____
☐ ☐ Have you had any surgeries recently? _____

Please DESCRIBE ANY other Medical Treatment, impending operations or other medical or dental information that the doctor should know about. _____

Name of your Medical Physician _____ Physician's Phone # _____

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Dental History

Yes No

- ☐ ☐ Are you experiencing pain or discomfort from your mouth at this time?
- ☐ ☐ Have you had swollen areas of the gums?
- ☐ ☐ When did you last have your teeth cleaned? Date _____
- ☐ ☐ How often do you usually have your teeth cleaned? _____
- ☐ ☐ Have you ever had gum (periodontal) treatments?
- ☐ ☐ Do your gums bleed?
- ☐ ☐ Are you aware of any loose teeth presently?
- ☐ ☐ Have you noticed any bad mouth odors or tastes?
- ☐ ☐ Have you ever had trench mouth?
- ☐ ☐ Are your teeth sensitive to sweets, hot or cold?
- ☐ ☐ Do you use dental floss or gum stimulators daily?
- ☐ ☐ Have you ever worn braces to straighten your teeth?
- ☐ ☐ Have you ever had your bite adjusted due to tooth grinding?
- ☐ ☐ Would you be disturbed if you had to lose your teeth and wear dentures?
- ☐ ☐ Are you satisfied with the appearance of your teeth?
- ☐ ☐ Are you now under more nervous tension than usual?
- ☐ ☐ Are you aware of clenching, gritting, or grinding your teeth? ☐ Day ☐ Night
- ☐ ☐ Do you have headaches regularly? ☐ Mornings ☐ Nights
- ☐ ☐ Do you frequently have pain about your ears, temples, or neck?
- ☐ ☐ Do you chew on only one side of your mouth? If so, why? _____
- ☐ ☐ Have you ever had prolonged bleeding following extractions in the past?
- ☐ ☐ Do you ever have canker sores?
- ☐ ☐ Have you ever had treatment for a tumor, growth, or cancer in or around your mouth?
- ☐ ☐ Has anyone in your family ever had tumors, growths or cancer in the mouth?
- ☐ ☐ Did either parent lose all of their teeth?

Who referred you to our office? _____

General Dentist _____ How Long? _____ Phone No. _____

Pharmacy Name _____ Phone No. _____

Who is responsible or guarantees payment for treatment? _____

Relationship to patient _____ Date of Birth _____

SS# _____ Driver's License # _____

Signed _____ Signed _____

D.D.S. *Patient or Legal Guardian*