Topeka Periodontics

Facial Esthetics
TOPEKA PERIODONTICS

Patient's Name: _____
First Middle Last

Social Security #: _____ Date of Birth: _____ Age: _____ Sex: M❑ F❑

Home Address: _____

_____
City State Zip Code

Home Phone: _____ Cell Phone: _____

E-Mail: _____

Name of Employer: _____

Occupation: _____ Business Phone: _____

Whom may we thank for referring you? _____

Notify in case of emergency: _____ Phone: _____

Best way to contact you:
- ❑ phone call
- ❑ text message
- ❑ e-mail

ORAL & FACIAL HISTORY

What brings you in today? _____

Are you having any dental discomfort today? _____

General Dentist: _____

Date of last dental care: _____ How many times have you had your teeth cleaned in the past 5 years: _____

Previous periodontal treatment: _____ Date of treatment: _____

CHECK YES OR NO:	YES	NO		YES	NO		YES	NO
Bad breath	❑	❑	Difficulty opening or closing your mouth	❑	❑	Loose teeth or broken fillings	❑	❑
Bleeding gums	❑	❑	Difficulty chewing	❑	❑	Migraine or tension headaches	❑	❑
Clicking or popping jaw	❑	❑	Food collection between teeth	❑	❑	Sensitivity to temperature	❑	❑
Dental implant(s)	❑	❑	Grinding or clenching teeth	❑	❑	Sores or growths in mouth	❑	❑

Do you wear an occlusal/night guard? YES❑ NO❑ _____

How do you feel about your smile? _____

Have you ever had neurotoxin (i.e. Botox) injections to relax your facial muscles? YES❑ NO❑ If yes, when? _____

Have you ever had dermal fillers to replace tissue volume loss? YES❑ NO❑ If yes, when? _____

Have you ever had braces? YES❑ NO❑ If yes, when? _____

Other information about your dental health or previous treatment: _____

MEDICAL HISTORY

Physician's Name: _____ Phone: _____ Date of last visit: _____

Have you had any serious illnesses or operations? **YES** ❑ **NO** ❑ If yes, describe: _____

Are you currently under physician care? **YES** ❑ **NO** ❑ If yes, describe: _____

PLEASE CHECK ALL THAT APPLY:

- ❑ AIDS/HIV positive
- ❑ Anaphylaxis
- ❑ Anemia
- ❑ Anxiety/Depression
- ❑ Arthritis/Rheumatism
- ❑ Artificial heart valves
- ❑ Artificial joint
- ❑ Asthma
- ❑ Back problems
- ❑ Blood thinner medications
- ❑ Cancer
- ❑ Chemical dependency
- ❑ Chemotherapy
- ❑ Cold sores
- ❑ COPD
- ❑ Diabetes
- ❑ Food allergies
- ❑ Headaches
- ❑ Heart problems (describe):

  _____

  _____

  _____
- ❑ Hemophilia/Abnormal bleeding
- ❑ Hepatitis
- ❑ High blood pressure
- ❑ HPV
- ❑ Jaw pain
- ❑ Kidney disease/malfunction
- ❑ Liver disease
- ❑ Material allergies (latex, wool, metal or chemicals)

  _____
- ❑ Pacemaker/Heart surgery
- ❑ Psychiatric care
- ❑ Rapid weight gain or loss
- ❑ Radiation treatment
- ❑ Respiratory disease
- ❑ Shingles
- ❑ Shortness of breath
- ❑ Skin rash
- ❑ Stroke
- ❑ Swelling of feet or ankles
- ❑ Thyroid disease/malfunction
- ❑ Tobacco habit
- ❑ Ulcer/Colitis
- ❑ Vitamin D deficiency

Women only:

- ❑ Pregnant
- ❑ Nursing
- ❑ Taking birth control pills

PLEASE PROVIDE A CURRENT LIST OF MEDICATIONS YOU ARE TAKING:

_____

_____

_____

_____

DO YOU HAVE DRUG ALLERGIES? IF YES, LIST ALL:

_____

_____

_____

_____

PREFERRED PHARMACY — *Include Street & City* **:** _____

Is there anyone you give us permission to share your information with? **YES** ❑ **NO** ❑ If so, who? _____

AUTHORIZATION AND RELEASE

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that Topeka Periodontics will use this information to help determine appropriate and healthful treatment. If there is any change in my medical status, I will inform the dentist.

I authorize Topeka Periodontics to share treatment recommendations and progress reports with my dental and medical teams as necessary for optimal coordination of patient care. 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 charges whether or not paid by insurance.

Signature _____ Date _____