Topeka Periodontics

Patient's Name: _____

First *Middle* *Last*

Date of Birth: _____ Age: _____ Sex: ☐ M ☐ F

Social Security Number: _____

Home Address: _____

City _____ *State* _____ *Zip* _____

What's the best way for us to contact you? _____

Telephone: *Home* _____ *Cell* _____ *Work* _____

Name of Employer: _____

Occupation: _____

E-mail Address: _____

Spouse: *Name* _____ *Employer* _____

If Patient is a minor: *Parents' Names* _____

Name of Dentist Who Referred You: _____

Preferred Pharmacy: _____

Dental Insurance Co: _____

Is there anyone you give us permission to share your information with? ☐ Yes ☐ No

If so, who? _____

Your privacy is of our utmost concern. All employees of our office will do everything possible to protect it. A copy of our complete privacy policy is located in our waiting room.

Patient Dental History

	Yes	*No*
Do your gums bleed while brushing or flossing?	☐	☐
Are your teeth sensitive?	☐	☐
Are you experiencing pain from your mouth at this time?	☐	☐

If so, explain: _____
_____
_____

How many times have you had your teeth cleaned in the last 5 years? _____

Have you had previous periodontal treatments?
When? _____

Would you be disturbed if you had to lose your teeth and wear false teeth?	☐	☐
Have you ever fainted in a dental office?	☐	☐

Have you experienced any of the following problems in your jaw?

Clicking?	☐	☐
Pain (joint, ear, side of face)?	☐	☐
Difficulty in opening or closing?	☐	☐
Difficulty in chewing?	☐	☐
Do you have frequent headaches?	☐	☐
Do you clench/grind your teeth?	☐	☐
If so, do you wear a night guard?	☐	☐
Do you bite your lips or cheeks frequently?	☐	☐
Have you had any orthodontics (braces)?	☐	☐
Have you ever had any prolonged bleeding following extractions?	☐	☐

Patient Medical History

Physician: _____
Date of Last Exam: _____
Height: _____ Weight: _____

	Yes	No
Are you under medical treatment now?	☐	☐
Have you ever been hospitalized for any surgical operation or serious illness?	☐	☐
Are you taking any medication(s) including over-the-counter medications/supplements? *If yes, what are you taking?* _____ _____	☐	☐
Are you taking a prescription blood thinner? *(e.g., Plavix, Coumadin)*	☐	☐
Do you use tobacco?	☐	☐
Have you been told to take an antibiotic pre-medication prior to dental work?	☐	☐
Are you allergic to or have you had reactions to the following?	☐	☐
Local Anesthetics *(e.g. Novocain)*	☐	☐
Penicillin or other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Sedatives	☐	☐
Other _____		
Can you take NSAIDS? (e.g., Ibuprofen, Naproxen)	☐	☐
Women Only:		
Are you pregnant or think you may be?	☐	☐
Are you nursing?	☐	☐
Are you taking birth control?	☐	☐

Do you have or have you had any of the following?

	Yes	No		Yes	No
High Blood Pressure	☐	☐	Emphysema	☐	☐
Diabetes	☐	☐	Cancer	☐	☐
Heart Attack	☐	☐	Arthritis	☐	☐
Rheumatic Fever	☐	☐	Joint Replacement	☐	☐
Swollen Ankles	☐	☐	Hepatitis/Jaundice	☐	☐
Fainting/Seizures	☐	☐	HPV	☐	☐
Asthma	☐	☐	Stomach Issues/Ulcers	☐	☐
Epilepsy/Convulsions	☐	☐	Chest Pains	☐	☐
Leukemia	☐	☐	Easily Winded	☐	☐
Kidney Diseases	☐	☐	Stroke	☐	☐
AIDS or HIV Infection	☐	☐	Hay Fever/Allergies	☐	☐
Thyroid Problem	☐	☐	Tuberculosis	☐	☐
Heart Disease	☐	☐	Radiation Therapy	☐	☐
Low Blood Pressure	☐	☐	Glaucoma	☐	☐
Cardiac Pacemaker	☐	☐	Recent Weight Loss	☐	☐
Heart Murmur	☐	☐	Liver Disease	☐	☐
Mitral Valve Prolapse	☐	☐	Heart Trouble	☐	☐
Angina	☐	☐	Respiratory Problems	☐	☐
Frequently Tired	☐	☐	Other _____	☐	☐
Anemia	☐	☐			

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____

Signature of patient or parent of minor *Date*