

## PATIENT INFORMATION FORM

Date \_\_\_\_\_

Why are you now seeking treatment? \_\_\_\_\_

Mr., Ms. Dr. \_\_\_\_\_ Age \_\_\_\_\_

Birth Date \_\_\_\_\_ Marital Status \_\_\_\_\_ Phone: H (\_\_\_\_) \_\_\_\_\_ W (\_\_\_\_) \_\_\_\_\_

Cell Phone (\_\_\_\_) \_\_\_\_\_ E-mail \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ ZIP \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Name of Spouse \_\_\_\_\_ Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Name of Dentist \_\_\_\_\_ How Long? \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Name of Physician \_\_\_\_\_ How Long? \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

In case of emergency please notify \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

**Dental Insurance:**  Yes  No Name/Address of Insured (if different from above) \_\_\_\_\_

Relationship to patient  Self  Spouse  Child  Other Insured SS # \_\_\_\_\_ Birth Date \_\_\_\_\_

Name/Address of Insurance Co. \_\_\_\_\_

### 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) Have you been told to take an antibiotic before your dental treatment? .....  No  Yes
- (11) 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/Cortisone 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/Jaundice |
| <input type="checkbox"/> Heart Attack     | <input type="checkbox"/> Stroke                     | <input type="checkbox"/> Glaucoma                     | <input type="checkbox"/> Liver Disease      |
| <input type="checkbox"/> Heart Disease    | <input type="checkbox"/> Diabetes                   | <input type="checkbox"/> Ulcers                       | <input type="checkbox"/> Venereal Disease   |
| <input type="checkbox"/> Heart Surgery    | <input type="checkbox"/> Family History of Diabetes | <input type="checkbox"/> Kidney Disorder              | (Herpes, Gonorrhea, Syphilis)               |
| <input type="checkbox"/> Heart Pacemaker  | <input type="checkbox"/> Osteoporosis               |   |   |
| <input type="checkbox"/> Other _____      |   |   |   |

**OVER →**

Practice Limited to Periodontics with Services in Dental Implants

Web: www.gumdrs.com

E-mail: ask@gumdrs.com

FAX (216) 464-7338

Parkway Medical Building NORTH BLDG.  
3609 Park East Dr., Suite 411  
Beachwood OH 44122-4309

(216) 464-8985

34501 Aurora Rd., Suite 208  
Solon OH 44139

(440) 248-1623

**Please check the correct response:**

- (12) Have you ever or are you presently undergoing psychiatric care?..... No Yes
- (13) Have you ever experienced an unusual reaction to dental local anesthesia ("Novocaine")? ..... No Yes
- (14) Are you allergic to any drugs or latex? ..... No Yes  
If yes, please indicate: Penicillin Aspirin Codeine Latex  
Other \_\_\_\_\_
- (15) Have you taken any prescription drugs or medications during the last year? ..... No Yes  
If yes, please list: \_\_\_\_\_  
\_\_\_\_\_
- (16) Are you presently taking any herbal or vitamin preparations? ..... No Yes  
If yes, please list \_\_\_\_\_
- (17) Do you take aspirin daily? No Yes Do you take nonsteroidal anti-inflammatories (like Advil) daily? ..... No Yes
- (18) WOMEN Are you pregnant at this time? No Yes Do you take birth control pills or have you in the past? . No Yes
- (19) WOMEN Are you in or have you completed menopause? ..... No Yes
- (20) WOMEN Have you had a hysterectomy or ovariectomy?..... No Yes

**DENTAL HISTORY**

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

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

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

**Signature** \_\_\_\_\_