W E S T E R N R E S E R V E P E R I O D O N T I C S , I N C .

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MINOR PATIENT INFORMATION FORM

(The following information is strictly confidential.)

Date _____

Patient Name _____ Age _____

Why are you now seeking periodontal treatment? _____

Birth Date _____ Male _____ Female _____ Home Phone ( ) _____

Address _____ City _____ ZIP _____

Name of Dentist _____ How Long? _____ Phone ( ) _____

Name of Physician _____ How long? _____ Phone ( ) _____

Parent or Responsible Party _____ Relationship to Patient _____

Address _____ City _____ ZIP _____

Home Phone ( ) _____ Work Phone ( ) _____

Dental Insurance: ❑Yes ❑No Insured SS No.: _____

Whom may we thank for referring you? _____

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

❑Other _____

OVER ➔

Please check the correct response:

11) Have you ever or are you 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 drugs or medications and have you taken any during the last year? ❑No ❑Yes

If yes, please list:_____

15) Are you presently taking any herbal or vitamin preparations? ❑No ❑Yes

If yes, please list _____

16) Do you take aspirin or nonsteroidal anti-inflammatories (like Advil) on a daily basis? ❑No ❑Yes

17) FEMALES: Are you pregnant at this time? ❑No ❑Yes

Do you take birth control pills or have you in the past? ❑No ❑Yes

DENTAL HISTORY

18) How often do you go to the dentist?_____ Date of last visit_____

19) What was done at that time?_____

20) When were your teeth last cleaned?_____

21) Have you had previous periodontal treatment? ❑No ❑Yes

If yes, describe treatment_____ When_____

22) Have you had previous orthodontic treatment? ❑No ❑Yes

23) Have you ever had an injury to the face or jaws? ❑No ❑Yes

24) Are you satisfied with your dental appearance? ❑No ❑Yes

25) Do you feel that your teeth bite together properly? ❑No ❑Yes

26) Do you notice food catching between your teeth frequently? ❑No ❑Yes

27) How often do you brush your teeth?_____ ❑Hard ❑Medium ❑Soft Brush

28) Do you use any other oral hygiene devices or materials? ❑No ❑Yes

If yes, what and how often?_____

29) Do your gums bleed when you brush your teeth? ❑No ❑Yes

30) Are you aware of bad breath? ❑No ❑Yes

31) Do you have discomfort in your mouth now? ❑No ❑Yes

32) Have you had any extensive dental treatment? ❑No ❑Yes

If yes, explain_____

33) What kind of dental health do you think you are in?_____

34) 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_____

Relationship to Patient _____