WESTERN RESERVE PERIODONTICS, INC.

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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**

❑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:

(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_____