

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, Syphilis)
Heart Pacemaker Osteoporosis
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:

- 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 _____