thepracticesf
PERIODONTAL HEALTHCARE AND IMPLANT DENTISTRY

Patient Information

Today's Date ____ / ____ / ____
Name ____ Age ____ Date of Birth ____
Address ____ City ____ Zip ____
Telephone: Home (____) ____ Business (____) ____ Cell or Emergency (____) ____
E-mail ____
Employed by ____ How long? ____
Business Address ____ City ____ Zip ____
Occupation ____ Driver's License # ____ S.S.# ____
School/City (if a full time student over 18) ____

Name of Spouse, Partner, or Parent ____ Employed by ____ How long? ____
Business Address ____ City ____ Zip ____
Business phone (____) ____ Occupation ____

Who may we thank for referring you? ____

If You Have Dental Insurance, Please Complete The Following:

PATIENT'S DENTAL INSURANCE
Name of Insured ____
S.S.# ____ Date of Birth ____
Insurance Co. ____
Address ____
Telephone (____) ____
Policy or Group # ____ Drug Coverage? ____

SECONDARY DENTAL INSURANCE
Name of Insured ____
S.S.# ____ Date of Birth ____
Insurance Co. ____
Address ____
Telephone (____) ____
Policy or Group # ____ Drug Coverage? ____

I authorize release of any information relating to this claim. I also hereby authorize payment of the group insurance benefits otherwise payable to me directly to The Practice SF.

x ____
Signed (insured person)

Dental History

Your General Dentist ____ Telephone (____) ____ For how long? ____
Present problem ____
Last cleaning (scaling, prophylaxis) ____ How often are your teeth cleaned? ____
Do your gums bleed? ____ When? ____

Doctor Notes:

• Are your gums, teeth, or mouth sore?	☐ Yes	☐ No	☐ Not Sure
• Do you get mouth infections or sores on your lips?	☐ Yes	☐ No	☐ Not Sure
• Do you have a bad taste or odor in your mouth?	☐ Yes	☐ No	☐ Not Sure
• Have you been told you have gum disease?	☐ Yes	☐ No	☐ Not Sure
• Have you had gum treatment?	☐ Yes	☐ No	☐ Not Sure
• Have you had orthodontic treatment?	☐ Yes	☐ No	☐ Not Sure
• Have your teeth become loose or have drifted?	☐ Yes	☐ No	☐ Not Sure
• Have you had gum boils or abscesses?	☐ Yes	☐ No	☐ Not Sure
• Do you have discomfort with opening, biting or chewing?	☐ Yes	☐ No	☐ Not Sure
• Does your jaw make popping or clicking noises?	☐ Yes	☐ No	☐ Not Sure
• Do you clench or grind your teeth (If yes, when)?	☐ Yes	☐ No	☐ Not Sure
• Does the appearance of your mouth trouble you?	☐ Yes	☐ No	☐ Not Sure
• Have you ever had complications with any dental treatment?	☐ Yes	☐ No	☐ Not Sure
• Have you ever had injuries or trauma to jaw or teeth?	☐ Yes	☐ No	☐ Not Sure

• How often do you brush your teeth? ____ ☐ Electric toothbrush ☐ Manual toothbrush - ☐ Hard ☐ Med. ☐ Soft
• Check other items used: ☐ Floss ☐ Toothpicks ☐ Water Irrigator ☐ Proxabrush ☐ Other ____
• What concerns do you have about dental treatment that you would like us to know? ____

Dental History

Name of Physician ____ Telephone (____) ____ City ____ Specialty ____
Name of Physician ____ Telephone (____) ____ City ____ Specialty ____
If member of group health plan (such as Kaiser), your member number ____
How would you rate your health (please circle): Excellent Good Fair Poor

Medical History Continued

Doctor Notes:

- Have you been under the care of a physician in the past 2 years? ☐ Yes ☐ No ☐ Not Sure
  If so, for what problem? _____
- Date of last medical exam _____. Any significant findings? _____
- Have you been hospitalized in past 5 years? ☐ Yes ☐ No ☐ Not Sure
  If so, for what problem? _____
- Have you had excessive bleeding that was difficult to stop? ☐ Yes ☐ No ☐ Not Sure
- Have you or any immediate family member had diabetes? ☐ Yes ☐ No ☐ Not Sure
- Have you or any immediate family member had a reaction or a problem with local or general anesthetics? ☐ Yes ☐ No ☐ Not Sure
- Have you lost or gained more than 10lbs. in the past year? ☐ Yes ☐ No ☐ Not Sure
- Have you had excessive thirst or dry mouth? ☐ Yes ☐ No ☐ Not Sure
- Do you need to urinate frequently? ☐ Yes ☐ No ☐ Not Sure
- Do you heal slowly or bruise easily? ☐ Yes ☐ No ☐ Not Sure
- Do you smoke? ☐ Yes ☐ No
  If so, how much per day? _____
- Have you smoked in the past? ☐ Yes ☐ No
  If so, when did you quit? _____

Women Only

- Are you pregnant? ☐ Yes ☐ No ☐ Not Sure
  If yes, what month of pregnancy? _____
- Are you planning to become pregnant? ☐ Yes ☐ No ☐ Not Sure
- Have you undergone, or are you undergoing menopause? ☐ Yes ☐ No ☐ Not Sure
  If so, do you have any symptoms? _____
- Are you taking hormone pills or shots? (including birth control) ☐ Yes ☐ No ☐ Not Sure

Doctor Notes:

1. In the last 12 months have you taken drugs, pills or medicines for:

Yes No
- ☐ ☐ Diabetes (pills or 'shots`)
- ☐ ☐ Nerves (tranquilizers)
- ☐ ☐ Sleeping
- ☐ ☐ Heart problems
- ☐ ☐ High blood pressure
- ☐ ☐ Blood (liver or iron pills, etc.)
- ☐ ☐ Stomach trouble (ulcer or other)
- ☐ ☐ Headaches
- ☐ ☐ Arthritis or rheumatism
- ☐ ☐ Osteoporosis
- ☐ ☐ Allergy
- ☐ ☐ Thyroid
- ☐ ☐ Diet

2. In the last 12 months have you taken any of these medications?

Yes No
- ☐ ☐ Hormones (including birth control pills)
- ☐ ☐ Aspirin or blood thinners
- ☐ ☐ Fosamax, Actonel, Skelid, Didronel
- ☐ ☐ Vitamins
- ☐ ☐ Dilantin
- ☐ ☐ Steroids (such as Cortisone)
- ☐ ☐ Phen Fen
- ☐ ☐ Viagra
- ☐ ☐ Other _____

3. List all medications you are Currently taking:

_____

_____

_____

4. Have you become sick from, shown an allergy to, or been told not to take:

Yes No
- ☐ ☐ Penicillin
- ☐ ☐ Other antibiotics _____
- ☐ ☐ Codeine or other pain relievers
- ☐ ☐ Novocaine, Xylocaine or other dental anesthetics
- ☐ ☐ Aspirin
- ☐ ☐ Latex
- ☐ ☐ Other _____

5. Have you ever had any of the following:

Yes No
- ☐ ☐ Heart disease
- ☐ ☐ Heart surgery
- ☐ ☐ Shortness of breath with mild exercise or when lying down
- ☐ ☐ Swelling of ankles or feet
- ☐ ☐ Pain, pressure, or tight feeling in chest (angina)

6. Have you ever had any of the following:

Yes No
- ☐ ☐ Pacemaker or artificial heart valve
- ☐ ☐ Mitral valve prolapse or heart valve surgery
- ☐ ☐ Heart murmur
- ☐ ☐ Stroke
- ☐ ☐ Rheumatic fever or scarlet fever
- ☐ ☐ Artificial joint or implant
- ☐ ☐ High blood pressure
- ☐ ☐ Diabetes
- ☐ ☐ Fainting, convulsions, epilepsy
- ☐ ☐ Frequent or severe headaches
- ☐ ☐ Blood transfusion
- ☐ ☐ Kidney disease
- ☐ ☐ Lung or breathing disease (TB, asthma, emphysema)
- ☐ ☐ Hepatitis, liver disease, jaundice
- ☐ ☐ Arthritis, sore joints
- ☐ ☐ Organ transplant
- ☐ ☐ Tumor, cancer or chemotherapy
- ☐ ☐ Blood disorder (anemia, leukemia, sickle cell)
- ☐ ☐ VD or urinary infections
- ☐ ☐ Radiation or cobalt treatments
- ☐ ☐ Alcohol or drug problem
- ☐ ☐ Positive HIV virus or HIV related disease

Reviewed by _____ **Date** _____

Please explain any disease or problem not listed above that I should know about _____

- I authorize The Practice SF to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs.
- Based on my need for periodontal care, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
- I understand that I am responsible for all costs of dental treatment.
- I have answered this information form as completely as possible.

_____
Signed (patient or parent if a minor) Date