Patient Information Registration Form

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Today's Date _____

Patient's Name _____
Last First Middle

Street Address _____

City and State _____ Zip Code _____

Email_____ Telephone Number_____ Cell Number _____

Social Security Number _____ Marital Status _____

Ohio Driver's License_____

Date of Birth (Month, Day, Year) _____

Relationship to Insured _____

Insurance Company Name_____

Second Insurance Company Name _____

Place of Employment _____ Business Phone No. _____

Occupation _____

Spouse's Name _____

Spouse's Employer _____

Two relations to call in case of emergency or if we are unable to reach you

(1) _____ phone _____ (2) _____phone_____

Name of Referring Dentist _____

Name of Physician _____

Since periodontal disease is produced by a combination of many complex elements, it is necessary to resolve every possible contributing factor. The success of therapy Is most dependent upon this. Though some of the following questions may seem unrelated to your gum condition, they are all associated with proper management of your oral health.

Please fill in questions or circle yes or no, whichever applies.

PRESENT HEALTH:

1. How would you describe your present health? Excellent ☐ Good ☐ Fair ☐ Poor ☐
2. Has there been any change in your health in the past year? ..... Yes ☐ No ☐
3. Are you now under the care of a physician? ..... Yes ☐ No ☐
4. Date of last physical exam? _____
5. What medications are you presently taking? _____

(Please write in the names of pills you are still taking as written on the drug bottles)

PAST MEDICAL HISTORY:

6. Have you been a patient in a hospital during the past 5 years? ..... Yes ☐ No ☐
7. Have you had any serious illness or operation? ..... Yes ☐ No ☐
   If so, what and when? _____
8. Have you ever taken Cortisones? ..... Yes ☐ No ☐

CARDIOVASCULAR:

9. Have you ever had any heart trouble? Murmurs? Stroke? Chest Pain? ..... Yes ☐ No ☐
10. Have you ever taken anticoagulants (blood thinners)? ..... Yes ☐ No ☐
11. Has your blood pressure ever been too high or too low? ..... Yes ☐ No ☐
12. Have you ever had Rheumatic fever or Rheumatic heart disease? ..... Yes ☐ No ☐
13. Do your ankles often become swollen? ..... Yes ☐ No ☐
14. How many pillows do you sleep on? 0
15. Are you subject to fainting spells? ..... Yes ☐ No ☐
16. Do you suffer from angina? ..... Yes ☐ No ☐

BLOOD:

17. Have you ever had anemia? ..... Yes ☐ No ☐
18. Have you ever had abnormal bleeding problems after a cut or tooth extraction? ..... Yes ☐ No ☐
19. Do you bruise easily? ..... Yes ☐ No ☐
20. Have you ever had severe or spontaneous nose bleeds? ..... Yes ☐ No ☐

RESPIRATORY:

21. Do you ever become short of breath? ..... Yes ☐ No ☐
22. When was your last chest x-Ray? _____
23. Do you have frequent colds that keep you out of work? ..... Yes ☐ No ☐
24. Have you ever had tuberculosis or a persistent cough? Bronchitis? ..... Yes ☐ No ☐
25. Do you breathe primarily through your mouth? ..... Yes ☐ No ☐
26. Do you have asthma or hay fever? ..... Yes ☐ No ☐

G.I. AND G.U.:

27. Have you ever had yellow jaundice or hepatitis? Liver problems? ..... Yes ☐ No ☐
28. Are you on any special diet ..... Yes ☐ No ☐
29. Have you ever had any gastrointestinal disorders? Ulcer? ..... Yes ☐ No ☐
30. Have you any kidney or bladder difficulty? Painful or frequent urination? Blood in urine? ..... Yes ☐ No ☐
31. Have you ever had syphilis or gonorrhea? VD? HIV? ..... Yes ☐ No ☐

FEMALES:

32. Are you pregnant? ..... Yes ☐ No ☐
33. Do you have any problems associated with your menstrual period? ..... Yes ☐ No ☐
34. Have you undergone, or are you presently undergoing, menopause? ..... Yes ☐ No ☐
35. Have you ever taken birth control medication? ..... Yes ☐ No ☐

ENDOCRINE:

36. Do you or any member of your family have diabetes? ..... Yes ☐ No ☐
37. Do you heal normally? ..... Yes ☐ No ☐ Slowly? ..... Yes ☐ No ☐
38. Have you ever received treatment for any endocrine or glandular disorder? Thyroid? ..... Yes ☐ No ☐

NERVOUS:

39. Do you suffer frequent or severe headaches? ..... Yes ☐ No ☐
40. Have you ever had severe pains of head or face? ..... Yes ☐ No ☐
41. Are you under tension? ..... Yes ☐ No ☐
42. Do you consider yourself excessively nervous? ..... Yes ☐ No ☐
43. Have you ever had epilepsy or convulsions? Dizzy spells? Blackouts? ..... Yes ☐ No ☐

ALLERGIES:

44. Are you sensitive or allergic to any particular medicines? ..... Yes ☐ No ☐
    (Aspirin, Penicillin, Novocaine) _____
45. Have you ever had hives or a rash? ..... Yes ☐ No ☐
46. Do you have an allergy? ..... Yes ☐ No ☐

OTHER: Are there any pills or medicines you must not take? ..... Yes ☐ No ☐

47. Have you ever been treated for any skin disease? ..... Yes ☐ No ☐
48. Have you ever received x-Ray or Radioactive Isotope treatment? ..... Yes ☐ No ☐
49. Has a doctor ever told you that you had a tumor or cancer? ..... Yes ☐ No ☐
50. Have you ever had Glaucoma, Arthritis, Pneumonia? ..... Yes ☐ No ☐
51. Have you recently gained or lost weight? ..... Yes ☐ No ☐
52. Do you smoke? ..... Yes ☐ No ☐ Packs per day 0
53. Do you drink alcohol on a daily basis or have you been treated for alcohol abuse? ..... Yes ☐ No ☐
54. What is your weight? _____ Height? _____

PRESENT DENTAL HEALTH:

1. Please state briefly the reason for which you were referred to this office, and any additional comments you would like to make. _____

What was done at your last dental treatment?

2. Name of dentist_____How long _____
3. Are you having pain in your mouth now? Teeth, joint. ear, side of face? ..... Yes ☐ No ☐
4. How long since your last thorough dental examination? _____
5. Were X-rays of ALL teeth taken at that time? _____Were they cleaned? _____
6. How often do you have your teeth examined? _____Cleaned? _____X-rayed? _____
7. Do your gums bleed easily, feel tender or irritated? _____When? _____Where? _____
8. Are your teeth sensitive to hot, cold or sweets? ..... Yes ☐ No ☐
9. Do you consider yourself in good dental health? ..... Yes ☐ No ☐
10. Has the fear of discomfort kept you from regular dental visits? ..... Yes ☐ No ☐
11. Are you aware of a bad taste or odor in your mouth? ..... Yes ☐ No ☐
12. Have you ever had an acute sore mouth or gum boils? “Trench mouth” or Vincent’s Infection? ..... Yes ☐ No ☐
13. Do you ever have fever blisters on your lips or mouth? ..... Yes ☐ No ☐
14. Does food generally wedge between certain teeth? Where? ..... Yes ☐ No ☐
15. Have you noticed any loosening of your teeth? ..... Yes ☐ No ☐
16. Have you ever found yourself grinding. clenching, or gritting your teeth? ..... Yes ☐ No ☐
    Day_____ Night_____
17. Does your jaw ever click or cause pain on opening or closing? ..... Yes ☐ No ☐
18. Have you noticed any shift in your teeth or bite? ..... Yes ☐ No ☐
19. Have your front teeth separated creating spaces in them recently? ..... Yes ☐ No ☐
20. Do you chew on one side of your mouth? ... Hold foreign objects with the teeth? ..... Yes ☐ No ☐
21. Have you ever had your teeth ground or the bite adjusted? ..... Yes ☐ No ☐
22. Have you lost any teeth other than wisdom teeth? ..... Yes ☐ No ☐
    Have they been replaced? .....Yes No When? _____
    If so, what was your choice? Gold? ☐ Silver? ☐ Porcelain? ☐ Plastic? ☐
23. Would you like to retain your healthy natural teeth as long as possible? ..... Yes ☐ No ☐
24. Did you wear braces for straightening your teeth? ..... Yes ☐ No ☐
25. Have you ever worn any dental appliances? ..... Yes ☐ No ☐
26. Have you had the nerves of any teeth removed? ..... Yes ☐ No ☐
27. Have you ever been instructed in the care of your gums or prevention of decay? ..... Yes ☐ No ☐
28. Have you ever had previous periodontal or gum treatment? ..... Yes ☐ No ☐
    When? _____ Where _____
29. Do you have Sleep Apnea or wear a sleep appliance ..... Yes ☐ No ☐

PLEASE ADD ANY INFORMATION YOU FEEL WAS NOT COVERED

I hereby give my permission to _____ and/or the doctor(s) in charge to administer any treatment; or to administer such anesthetics, and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of the patients named below.

Authorization must be signed by the patient, or by the nearest relative in the case of a minor or when the patient is physically or mentally incapable.

☐ It is agreed that any unpaid balance over ninety days will be subject to a 0.85% monthly service charge.

Initials _____ Date: _____
(Patient, Parent or Guardian)

Reviewed by: _____