If yes, please list: ___

Practice Limited to Periodontics and Dental Implants

				RMATION		_						
Name _						T D	oday's ate	Age		Birth _ Date	Marital Status	
Address						c	ity		Zip	Phone _		
Email										Cell Phone _		
To confir	m appointments, ho	w would y	ou like to	be notified? Ema	ail 🗖	— н	ome Phone		(Call Cell Phone 🗖		ext 🗆
Occupati	ion					E	Employed By	<u>/</u>				
Business	Address					c	ity		Zip	Phone		
	Spouse											
	ion											
	of emergency, who n											
		-										
	Dentist											
Name of	Physician					C	ity			Last Physical		_
Referred	to this office by											_
What is y	your reason for seek	ing period	ontal ca	re?								_
	Primary Dental Ca	arrier Insu	urance (Co.		s	econdary D	Dental Carr	ier Ins	urance Co.		
	Address					A	ddress					
	City, State, Zip					C	ity, State, Z	ip				
	Employee			D: (I) (_	mnlovoo			Birthdate		
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	signature or Guardian)	Date		
)_4! - ··· ()	☐ Check here that you have received a copy of This office's Notice of	-		•
	and the above information is necessary to provide me with dental care in the best of my knowledge.			
	If so, what is your biggest fear?			
19.	Are you apprehensive about dental treatment	YES□	NO□	
	Extremely Important	Not Important		
	10 20 30 40	5 □		
18.	Rate the importance you place upon keeping your remaining natural to			
	Do you use dental floss or toothpicks between your teeth?	YES	NO□	
	What type of toothbrush? ☐ Hard ☐ Medium ☐ Soft ☐ Ele		:	
16.	How often do you brush your teeth?			
	Have you ever had orthodontic treatment (braces)?	YES□	NO□	
	Have you ever been treated for pain in the jaw joints?	YES□	NO	
	in your jaw joints?	YES□	NO	
13.	When you chew, do you have clicking, popping or pain			
	Are you aware of grinding or clenching your teeth?	YES□	NO□	
4.0	chewing sweets?	YES□	NO	
11.	Are any of your teeth generally sensitive to heat, cold,	VEOR	NOG	
	Do you often develop cold sores or other oral lesions?	YES□	NO□	
9.	Have you noticed any mouth odors or bad tastes?	YES□	NO	
8.	Are you dissatisfied with the appearance of your teeth?	YES□	NO	
7.	Do you have difficulty chewing on either side of your mouth?	YES	NOU	
6.	Have you noticed any loose teeth or change in your bite?	YES□	NO	
5.	Do your gums ever bleed when you brush or floss?	YES□	NO	
_	If so, when?			
4.	Have you had previous periodontal (gum) treatment?	YES□	NO□	
J.				
3.	How often have you had your teeth cleaned in the past five years?			
2.	Date of last dental appointment What was done?			
1. 2	Are you experiencing discomfort from your mouth at this time?	YES□	NO□	
	DENTAL HIS			
	BENEFAL 199	NTORY .		
21.	Are you menopausal?	YES□	NO□	
	Are you taking birth control pills?	YES□	NO□	
19.	Are you nursing?	YES□	NO□	
18.	Are you pregnant? If yes, what month?	YES□	NO□	
	FOR WOMEN ONLY:			
	If yes, please list:			
	or problem not listed?	YES□	NO□	
17.	Do you have or have you had any disease, condition			
	If so,why?	. 202		
	Are you on a special diet or restricted diet now?	YES 🗆	NO 🗆	
	Have you ever had x-ray treatment for a tumor?	YES 🗆	NO 🗆	
	Do you smoke? How many packs per day?	YES 🗆	NO 🗆	
	Do your ankles ever swell?	YES 🗆	NO	
12.		YES 🗆	NO□ NO□	
	Do you have frequent headaches? Do injuries or cuts heal very slowly?	YES 🗆	NOD	
9. 10	Do you have frequent colds or sinus trouble?	YES 🗆	NOD	
8.	Have you ever had excessive bleeding requiring special treatment?	YES□ YES□	NOD	
7.	Do you consider yourself to be under mental or emotional stress?	YESD	NO	
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