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NORTHERN VIRGINIA PERIODONTICS

PATIENT INFORMATION FORM

(The following information is strictly confidential)

Date _____

Why are you now seeking periodontal treatment? _____

Dr., Mr., Mrs., Miss, Ms. Name: _____ Age _____
Birth Date _____ Marital Status _____ Home Phone ( ) _____
E-mail _____ Cell Phone ( ) _____
Address _____ City _____ ZIP _____
Occupation _____ Employed By _____ Phone ( ) _____
Name of Spouse _____ Occupation _____ Employed By _____
Name of Dentist _____ How Long? _____
Name of Physician _____ How Long? _____ Phone ( ) _____
Whom may we thank for referring you? _____
Name of Dental Insurance Carrier (if any) _____
Patient's SS# _____ Insured SS# _____ Insured Birth Date _____
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 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 A
☐ Heart Attack	☐ Stroke	☐ Glaucoma	☐ Hepatitis B or C
☐ Heart Disease	☐ Diabetes	☐ Ulcers	☐ Jaundice
☐ Heart Surgery	☐ Family History of Diabetes	☐ Kidney Disorder	☐ Liver Disease
☐ Heart Pacemaker	☐ Venereal Disease (Herpes, Gonorrhea, Syphilis)		

☐ Other _____

OVER ➡

Please check the correct response:

(11) Have you ever or are 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 medications and have you taken any during the last year? ☐ No ☐ Yes
If yes, please list: _____
(15) Have you taken a drug from the bisphosphonate drug class (fosamax, actonel, boniva…)? ☐ No ☐ Yes
If yes, what drug and for how long? _____ Are you still taking the drug? ☐ No ☐ Yes
When did you stop?_____
(16) Do you "premedicate" with antibiotics prior to dental treatment? …… ☐ No ☐ Yes
(17) Do you take aspirin or nonsteroidal anti-inflammatories (like Advil) on a daily basis? …….. ☐ No ☐ Yes
(18) WOMEN Are you pregnant at this time? ……. ☐ No ☐ Yes
(19) WOMEN Are you or have you had menopause (change of life)? ……... ☐ No ☐ Yes
(20) WOMEN Have you had a hysterectomy or ovariectomy? …….. ☐ No ☐ Yes
(21) WOMEN Do you take birth control pills or have you in the past? …… ☐ No ☐ Yes

DENTAL HISTORY

(22) How often do you go to the dentist? _____ Date of last visit _____
(23) What was done for you at that time? _____
(24) When were your teeth last cleaned? _____
(25) Have you had previous periodontal treatment? ……. ☐ No ☐ Yes
If yes, describe treatment _____ When _____
(26) Have you had previous orthodontic treatment? ……. ☐ No ☐ Yes
(27) Have you ever had an injury to your face or jaws? ……... ☐ No ☐ Yes
(28) Are you satisfied with your dental appearance? …… ☐ No ☐ Yes
(29) Have any of your teeth changed position in recent years? …… ☐ No ☐ Yes
(30) Do you feel that your teeth bite together properly? …….. ☐ No ☐ Yes
(31) Do you notice food catching between your teeth frequently? …….. ☐ No ☐ Yes
(32) How often do you brush you teeth? _____ ☐ Hard ☐ Medium ☐ Soft Brush
(33) Do you use any other oral hygiene devices or materials? ……. ☐ No ☐ Yes
If yes, what and how often? _____
(34) Do your gums bleed when you brush your teeth? ……. ☐ No ☐ Yes
(35) Are you aware of bad breath? ……... ☐ No ☐ Yes
(36) Do you have discomfort in your mouth now? ……... ☐ No ☐ Yes
(37) Have you had any extensive dental treatment? ……. ☐ No ☐ Yes
If yes, explain _____
(38) Do you wear upper or lower complete or partial dentures? …….. ☐ No ☐ Yes
(39) What kind of dental health do you think you are in? _____
(40) Do you have any of the following habits?
☐ Grind teeth ☐ Bite lip, cheek, or tongue ☐ Clench teeth
☐ Smoke or chew tobacco presently or previously:
How much? _____ For how long? _____ Quit when? _____
(41) Please rank your overall stress level ☐ Low ☐ Moderate ☐ High

Is there any additional information which will help us to help you? _____

This medical/dental history is accurate to the best of my knowledge.

Patient Signature _____ Doctor Signature _____