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Periodontics & Dental Implants
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REGISTRATION / HISTORY

Date_____

Patient's Name_____ Birth Date_____ Height_____ Weight_____ Age_____

If Patient is a Child – Name of School Where Presently Enrolled_____

Single_____ Widowed_____ Married_____ Divorced_____ Separated_____

Street Address_____ Phone_____

City_____ State_____ Zip_____

Name of Spouse_____

If a Child, Parent's Name_____

Patient Employed by_____ Phone_____

Business Address_____

Present Position_____ How Long Held_____

Social Security No._____ Birth Date of Insured_____

Name of Insurance Company_____ Self ☐ Spouse ☐ Parent ☐ Group No._____

In case of Emergency, whom should be notified_____ Phone_____

Please answer each question. Check yes or no. If in doubt, leave blank.

	YES	NO
1. Are you in good health now?	☐	☐
2. Are you now under the care of a physician?	☐	☐
If so, what is the condition being treated _____		
3. Have you been hospitalized or had a serious illness in the past 2 years?	☐	☐
4. Have you tested positive to the HIV virus or had exposure to the virus?	☐	☐
5. Have you ever had excessive bleeding following an extraction, or do cuts take longer to heal now than previously?	☐	☐
6. Have you ever had hepatitis? (If yes, which type A, B or C)?	☐	☐
7. (Women) Are you pregnant? If so, give due date_____	☐	☐
8. Do you use tobacco in any form? If yes, how much_____	☐	☐
9. Do you drink alcoholic beverages (more that 2 drinks per day)?	☐	☐
10. Prosthetic (Artificial) joint replacement, hip, knee, etc?	☐	☐
11. Have you ever taken diet medication (Fen-Phen or Redux)?	☐	☐
12. Are you taking any bisphosphonate drugs for treatment of osteoporosis, osteosarcoma, or post menopausal bone loss? (Such as Fosamax, Aredia, Actonel or Zometa?)	☐	☐
13. Are you now taking Viagra	☐	☐
14. Are you allergic to Latex?	☐	☐

15. Do you have or have you ever had any of the following?

GENERAL

	YES	NO
Hemophilia	☐	☐
Sickle Cell Anemia	☐	☐
Kidney Disease	☐	☐
Cirrhosis / Jaundice	☐	☐
Cancer (Radiation / Chemotherapy)	☐	☐
Stomach Ulcers	☐	☐
High Blood Pressure	☐	☐
Glaucoma	☐	☐

NERVOUS SYSTEM

Stroke	☐	☐
Headaches	☐	☐
Seizures	☐	☐
Fainting	☐	☐
Psychiatric Treatment	☐	☐

RESPIRATORY SYSTEM

	YES	NO
Lung Disease	☐	☐
Tuberculosis	☐	☐
Emphysema	☐	☐
Asthma	☐	☐
Bronchitis	☐	☐
Shortness of Breath	☐	☐
Difficulty Breathing while lying down	☐	☐

ENDOCRINE

Diabetes	☐	☐
Family History of Diabetes	☐	☐
Thyroid Disease	☐	☐

CIRCULATORY SYSTEM

Congenital Heart Disease	☐	☐
Pacemaker	☐	☐
Irregular Heart Beat	☐	☐

	YES	NO
Heart Surgery	☐	☐
Mitral Valve Prolapse	☐	☐
Valve Replacement	☐	☐
Heart Attack	☐	☐
Rheumatic Fever	☐	☐
Angina / Chest Pain	☐	☐
Heart Murmur	☐	☐

15. Are you ALLERGIC or have you ever experienced any reaction to the following?

	YES	NO
Local anesthetics (e.g. Novacaine)	☐	☐
Barbiturates / Sedatives / Sleeping pills	☐	☐
Penicillin / other antibiotics	☐	☐
Demerol	☐	☐
Aspirin	☐	☐
Sulfa Drugs	☐	☐
Valium	☐	☐
Codeine	☐	☐

Other allergies_____

16. Are you taking any of the following?

	YES	NO
Antibiotics	☐	☐
Blood thinners	☐	☐
Blood pressure medication	☐	☐
Thyroid medicine	☐	☐
Cortisone /steroids	☐	☐
Antihistamines / allergy drugs / cold remedies	☐	☐
Tranquilizers	☐	☐
Insulin / other diabetes medications	☐	☐
Recreational drugs	☐	☐
Digitalis / other heart medications	☐	☐
Nitroglycerin	☐	☐
Aspirin	☐	☐

If yes to any of the above, list ***name*** of medication and ***dosage*** below:

1. _____
2. _____
3. _____
4. _____

17. Is there any disease, condition or problem not listed above that you think we should know about, or is there any activity your doctor says you cannot do? If so, explain _____

18. Physician's Name_____ Phone_____

19. Date of last Medical / Physical Examination_____

20. Have you ever had any serious trouble associated with previous dental treatment?_____

21. Date of last dental visit_____

22. Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)?_____

If so, when?_____

MOUTH

	YES	NO
Bleeding, sore gums	☐	☐
Unpleasant taste/bad breath	☐	☐
Burning tongue / lips	☐	☐
Frequent blisters, lips / mouth	☐	☐
Swelling / lumps in mouth	☐	☐
Ortho treatments (braces)	☐	☐
Biting cheeks / lips	☐	☐
Clicking / popping jaw	☐	☐
Difficulty opening or closing jaw	☐	☐

TEETH

	YES	NO
Loose Teeth	☐	☐
Sensitive to hot	☐	☐
Sensitive to cold	☐	☐
Sensitive to sweets	☐	☐
Sensitive to biting	☐	☐
Food impaction	☐	☐
Clenching / grinding	☐	☐
Shifting of teeth	☐	☐
Change in bite	☐	☐

ORAL HYGIENE

	YES	NO
Do you use the following?		
Brush	☐	☐
Dental Floss	☐	☐
Fluoride rinse	☐	☐

Other_____

How often do you brush?_____

Brush is: Soft ☐ Medium ☐ Hard ☐

Baseline BP_____ Pulse_____

To the best of my knowledge, all of the preceding answers are true and correct.
If I ever have any change in my health or change in my medication, I will inform the dentist at the next appointment.
I understand that I am financially responsible for payment of my account.

Signature of patient,
Parent or Guardian_____ Date_____

Reviewed by:_____ _____ _____ Date_____