DELAWARE PERIODONTICS
Specializing in Periodontics & Implantology

Patient Information & Health Questionnaire

❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms.
❑ Dr. ❑ Rev. ❑ Sr. ❑ Fr.

Today's Date_____

Patient's full name_____ _____ Birthdate _____
First Last

( ) Single ( ) Married

( ) Partner ( ) Widowed

( ) Divorced ( ) Dependent Child

Email Address _____

Soc. Sec. # _____

General Dentist_____

Sex: M ◯ F ◯

Physician Name _____

Address _____

Physician Address_____

City, State, Zip _____

Physician Phone # _____

Phone Home ( ) _____ Work ( ) _____ Cell ( ) _____

Preferred method of contact: Home Ph ◯ Work Ph ◯ Cell Ph◯ Email◯

Patient's Occupation _____ Employer _____

If patient is a full time student, what school? _____

In case of emergency, please notify: _____ Phone _____

Referred by: _____ Relationship _____

Check One: ( ) No Insurance ( ) Insurance ( ) Dual Insurance

Insurance Information Patients relationship to insured: ( ) Self ( ) Spouse ( ) Partner ( ) Child

Name of insured _____ Employer_____

Insurance Co. & Address _____ Work Phone _____ Birthdate _____

_____ Soc. Sec. # _____

_____ Group # _____ Employee # _____

If You Have Dual Coverage, Please Complete for Secondary Carrier:

Name of insured _____ Employer _____

Insurance Co. & Address _____ Work Phone _____ Birthdate _____

_____ Soc. Sec. # _____

_____ Group # _____ Employee # _____

I hereby authorize the release of my information.

_____ /_____/_____
Patient (parent if minor) Signature Date

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ANSWER ALL QUESTIONS BY CIRCLING YES OR NO & FILL IN ALL BLANK SPACES

Reason for seeking treatment_____

_____

☐ NO ☐ YES Has there been any change in your general health within the past year?
☐ NO ☐ YES Are you now under the care of a physician?
☐ NO ☐ YES Have you been hospitalized, or had a serious illness during the past five years?
☐ NO ☐ YES Are you pregnant, or anticipating pregnancy?

Have you taken any of the following drugs or medication in the past six months?

☐ NO ☐ YES Anticoagulants (blood thinners) - What?_____
☐ NO ☐ YES Medicine for high blood pressure or water pills - What?_____
☐ NO ☐ YES Cortisone (steroids) - What?_____
☐ NO ☐ YES Valium, Xanax, or tranquilizers - What?_____
☐ NO ☐ YES MAO inhibitors or other antidepressants - What?_____
☐ NO ☐ YES Aspirin
☐ NO ☐ YES Insulin, or pills for diabetes - What?_____
☐ NO ☐ YES Digoxin, or drugs for heart trouble - What?_____
☐ NO ☐ YES Nitroglycerin
☐ NO ☐ YES Birth control pills
☐ NO ☐ YES Dilantin
☐NO ☐ YES Bisphosphonates (Fosamax)

**** LIST ALL MEDICATIONS**_____

_____

Are you allergic to or had a reaction to:

☐ NO ☐ YES Novocain or dental anesthetics
☐ NO ☐ YES Penicillin or other antibiotics
☐ NO ☐ YES Aspirin, or other anti-inflammatory medications
☐ NO ☐ YES Codeine, or other narcotics
☐ NO ☐ YES Food
☐ NO ☐ YES Latex (gloves)

Other _____

Do you have, or have you had any of the following:

☐ NO ☐ YES Congenital heart disease
☐ NO ☐ YES Mitral Valve Prolapse
☐ NO ☐ YES Rheumatic fever, or rheumatic heart disease
☐ NO ☐ YES Heart murmur
☐ NO ☐ YES Heart trouble, heart attack, stroke, pacemaker, or prosthetic heart valve
☐ NO ☐ YES High blood pressure
☐ NO ☐ YES Asthma, or difficulty in breathing
☐ NO ☐ YES Diabetes
☐ NO ☐ YES Osteoporosis
☐ NO ☐ YES Artificial bones, or prosthetic joints implanted
☐ NO ☐ YES Blood disorders, anemia, or leukemia
☐ NO ☐ YES Stomach ulcers
☐ NO ☐ YES Colitis
☐ NO ☐ YES Kidney trouble, or renal dialysis

☐ NO ☐ YES Hepatitis, jaundice, or liver disease
☐ NO ☐ YES Chest pain after mild exercise
☐ NO ☐ YES Persistent cough, or coughing up blood
Other _____

Do you have, or have you had any of the following:

☐ NO ☐ YES Seizures, or convulsions
☐ NO ☐ YES Psychiatric disorder? Depression? Anxiety?
☐ NO ☐ YES Frequent urination (more than 6 times a day)
☐ NO ☐ YES Excessive thirst
☐ NO ☐ YES Arthritis
☐ NO ☐ YES Cancer
☐ NO ☐ YES Thyroid disease
☐ NO ☐ YES Surgery, or radiation treatment, for a tumor, growth, or other condition of your head, neck or mouth
☐ NO ☐ YES Venereal disease, gonorrhea, syphilis (bad blood)
☐ NO ☐ YES Contact with any individual having hepatitis, tuberculosis, AIDS, HIV+, or ARC
☐ NO ☐ YES Blood transfusion
☐ NO ☐ YES Have you ever been denied permission to give blood?
☐ NO ☐ YES Any problems associated with your menstrual period?
☐ NO ☐ YES Hearing, visual problems, or their disabilities that we should consider in planning your dental treatment. If yes, please explain_____
_____
Other_____

Do you have, or have you had any of the following:

☐ NO ☐ YES History of fever blisters, or cold sores
☐ NO ☐ YES Recurrent canker sores, mouth ulcers, or oral herpes infections
☐ NO ☐ YES Trouble with any previous dental treatment
☐ NO ☐ YES Excessive bleeding after extractions, surgery or wounds
☐ NO ☐ YES Frequent dry mouth
☐ NO ☐ YES Disease, condition or problem not listed

Do you have, or have you had any of the following:

☐ NO ☐ YES Dental pain or discomfort
☐ NO ☐ YES Dissatisfaction with the way your teeth look
☐ NO ☐ YES Problems chewing satisfactorily
☐ NO ☐ YES Uncomfortable bite
☐ NO ☐ YES Bleeding gums
☐ NO ☐ YES Bad taste in mouth, or bad breath
☐ NO ☐ YES Food packing between your teeth
☐ NO ☐ YES Loose teeth
☐ NO ☐ YES Habit of clenching or grinding your teeth together
☐ NO ☐ YES Other oral or tongue habits

Do you, or have you had any of the following:

☐NO ☐YES Clicking or popping in your jaw joint or ears when you open or close your jaw
☐NO ☐YES Locking jaw
☐NO ☐YES Frequent headaches
☐NO ☐YES Tooth sensitivity to hot or cold
☐NO ☐YES Orthodontic treatment
☐NO ☐YES Treatment by a periodontist
☐NO ☐YES Do you floss daily?
☐NO ☐YES Do you use mouthwash or mouth rinses?
☐NO ☐YES If you have removable partial dentures, are they unsatisfactory?

How often do you brush?_____

When was your last visit to a dentist? _____

How often to you see your regular dentist? _____

☐NO ☐YES Do you smoke? What? _____How many/day?_____
For how many years? _____
☐NO ☐YES Do you drink alcoholic beverages? What? _____
How much/day? _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient Signature _____ Date _____/_____/_____

Put all updated health history on separate page

Additional Comments:

SUBMIT