

FORM A

HEALTH QUESTIONNAIRE

The following information will make it possible for us to be more successful and thorough in your treatment. Your answers are for our records only and will be considered confidential.

Birth Date _____ Today's Date _____

Name _____ Home Address _____

Home Phone _____
City State Zip Code

Business Address _____
Company Name Number and Street

Business Phone _____
City State Zip Code

Age _____ Sex _____ Height _____ Weight _____ Occupation _____

Married _____ Single _____ Spouse's Name _____ Occupation _____

Closes Relative _____ Phone Number _____

Primary Physician _____ Address _____ Phone _____

Primary Dentist _____ Address _____ Phone _____

Last Physical Examination _____ Referred By _____

Last Dental Treatment _____ Procedure _____

Give your reason(s) for seeking periodontal treatment

Dental Insurance Information:

Social Security Number _____

Insurance Carrier Name _____

Insurance Group Number _____

Based on what your dentist has told you and what you know about your mouth, please rate the condition of your mouth on a scale of 1 to 10 where 1 is severe disease (anticipated loss of some teeth) and 10 is optimal health. _____

Form A, cont.

On the following questions, circle the correct answer, mark any question you are unsure of UNKNOWN.

				Comment
1. Are you experiencing pain from your mouth at this time?	NO	YES	UNKNOWN	Where?
2. Have you ever has periodontal (gum) treatment When? _____ When? _____ Doctor _____	NO	YES	UNKNOWN	
3. Did either your mother or father lose all their natural teeth?	NO	YES	UNKNOWN	
4. Have you had swollen areas on your gums, gum boils, or abscesses?	NO	YES	UNKNOWN	Which?
5. Do your gums bleed?	NO	YES	UNKNOWN	
6. Have you noticed bad odors or tastes?	NO	YES	UNKNOWN	Which?
7. Do you frequently breathe through your mouth?	NO	YES	UNKNOWN	
8. Do you chew gum, hard candies, or antacid tablets?	NO	YES	UNKNOWN	Which?
9. Do you frequently have fever blisters, mouth ulcers, or sores in your moth or on your lips?	NO	YES	UNKNOWN	
10. Have you ever had trench mouth?	NO	YES	UNKNOWN	When?
11. Do you have any teeth that are sensitive to heat, cold, or sweets?	NO	YES	UNKNOWN	Which?
12. Do you have any loose teeth?	NO	YES	UNKNOWN	
13. Have your teeth speared lately, creating spaces between them?	NO	YES	UNKNOWN	
14. Have you ever worn braces to straighten your teeth?	NO	YES	UNKNOWN	
15. Are you dissatisfied with the appearance of your teeth?	NO	YES	UNKNOWN	
16. Do foods wedge between your teeth?	NO	YES	UNKNOWN	
17. Have you been under more nervous tension than average lately?	NO	YES	UNKNOWN	Why?
18. Do you smoke?	NO	YES	UNKNOWN	What? How much?

				Comment
19. Are you aware of clenching, gritting, or grinding your teeth?	NO	YES	UNKNOWN	While awake? While asleep?
20. Are you aware of the way your teeth fit together?	NO	YES	UNKNOWN	
21. Do you chew on one side of your mouth?	NO	YES	UNKNOWN	Which?
22. Do you have headaches regularly?	NO	YES	UNKNOWN	Side of head? Migraine type?
23. Do you have any teeth which are tender to biting or pressure?	NO	YES	UNKNOWN	
24. Do you frequently bite your lip, cheek, fingernails, or objects (such as pipes, pencils, bobby pins)?	NO	YES	UNKNOWN	Which?
25. Do you frequently press your tongue against your teeth?	NO	YES	UNKNOWN	
26. Do you have any idea what periodontal treatments are and what they do for you?	NO	YES	UNKNOWN	Which?
27. Would you be tremendously disturbed if you had to lose your teeth and wear false teeth?	NO	YES	UNKNOWN	
28. Are you in good health?	NO	YES	UNKNOWN	When?
29. Are you willing to spend a total of 20 minutes daily for periodontal disease control?	NO	YES	UNKNOWN	Which?
30. Do you brush your teeth at least twice daily?	NO	YES	UNKNOWN	
31. Do you ever use dental floss, toothpicks, water sprays, or gum stimulators?	NO	YES	UNKNOWN	
32. Have you ever had a frightening experience with dentistry?	NO	YES	UNKNOWN	
33. Do you know that patients undergoing periodontal treatment experience minimal discomfort?	NO	YES	UNKNOWN	
34. Do you form calculus (tartar) or plaque rapidly on your teeth or been told you do?	NO	YES	UNKNOWN	
35. Has there been any change in your general health within the past year?	NO	YES	UNKNOWN	Which area?

				Comment
36. Are you under the care of a physician?	NO	YES	UNKNOWN	What for?
37. Have you ever had a major illness or operation?	NO	YES	UNKNOWN	What for?
38. Have you ever had any problems with surgery or anesthesia?	NO	YES	UNKNOWN	What?
39. Have you ever been hospitalized?	NO	YES	UNKNOWN	
40. Do you have or have you had any of the following diseases or conditions?				
- <i>rheumatic fever or rheumatic heart disease</i>	NO	YES	- <i>pacemaker</i>	NO YES
- <i>congenital heart problem (murmur, prolapsed valve)</i>	NO	YES	- <i>AIDS/HIV positive</i>	NO YES
- <i>heart attack</i>	NO	YES	- <i>arthritis</i>	NO YES
- <i>rheumatism (painful, swollen joints)</i>	NO	YES	- <i>stroke</i>	NO YES
- <i>hepatitis, jaundice or liver disease</i>	NO	YES	- <i>stomach ulcers</i>	NO YES
- <i>high blood pressure</i>	NO	YES	- <i>kidney trouble</i>	NO YES
- <i>low blood pressure</i>	NO	YES	- <i>tuberculosis</i>	NO YES
- <i>persistent cough or cough up blood</i>	NO	YES	- <i>arteriosclerosis</i>	NO YES
- <i>chest pain or exertion</i>	NO	YES	- <i>venereal disease</i>	NO YES
- <i>psychiatric treatment/counseling</i>	NO	YES	- <i>bypass surgery</i>	NO YES
- <i>shortness of breath</i>	NO	YES	- <i>anemia</i>	NO YES
- <i>swollen ankles</i>	NO	YES	- <i>glaucoma</i>	NO YES
- <i>hives or skin rash</i>	NO	YES	- <i>thyroid trouble</i>	NO YES
- <i>fainting spells or seizures (epilepsy)</i>	NO	YES	- <i>porphyria</i>	NO YES
- <i>illness that lasted more than one week</i>	NO	YES	- <i>Diabetes</i>	NO YES
- <i>Other</i>	NO	YES	- <i>allergy</i>	NO YES
41. Are you presently taking or have you taken any of the following drugs or medications with in the past year?				
- <i>antibiotics or sulfa drugs</i>	NO	YES	- <i>tranquilizers</i>	NO YES
- <i>anticoagulants (blood thinners)</i>	NO	YES	- <i>sleeping pills</i>	NO YES
- <i>medicine for high blood pressure</i>	NO	YES	- <i>vitamins</i>	NO YES
- <i>cortisone (steroids)</i>	NO	YES	- <i>aspirin</i>	NO YES
- <i>marijuana or other recreational drugs</i>	NO	YES	- <i>hormones</i>	NO YES
- <i>medication you purchase yourself without a prescription</i>	NO	YES	- <i>nitroglycerine</i>	NO YES
- <i>insulin, tolbutamide or similar drugs</i>	NO	YES	- <i>digitalis or similar drugs</i>	NO YES
- <i>other</i>	NO	YES	- <i>bisphosphonates</i>	NO YES
42. Do you have to urinate (pass water) more than 6 times a day?				
	NO	YES	UNKNOWN	
43. Are you thirsty much of the time?				
	NO	YES	UNKNOWN	
44. Does your mouth frequently become dry?				
	NO	YES	UNKNOWN	Day?____ Night?____
45. Do you feel numbness or tingling in any part of your body?				
	NO	YES	UNKNOWN	Where?
46. Have you had abnormal bleeding with extractions, surgery, or trauma?				
	NO	YES	UNKNOWN	
47. Do you bruise easily?				
	NO	YES	UNKNOWN	
48. Have you ever required a blood transfusion?				
	NO	YES	UNKNOWN	

49. Are you short of breath after climbing <u>one flight</u> of stairs?	NO	YES	UNKNOWN		
50. Are you short of breath after climbing <u>two flights</u> of stairs?	NO	YES	UNKNOWN		
51. Do you have any blood disorders?	NO	YES	UNKNOWN		
52. Have you had surgery or x-ray treatment for a tumor growth or malignancy?	NO	YES	UNKNOWN		
53. Are you employed in a situation which exposes you regularly to x-rays or ionizing radiation?	NO	YES	UNKNOWN		
54. Do you sleep well?	NO	YES	UNKNOWN		
55. Are your parents living?	NO	YES	UNKNOWN		
56. Has anyone in your family ever had: diabetes, tuberculosis, porphyria, heart disease, stroke, or any other disease or condition?	NO	YES	UNKNOWN	What? Who?	
57. Do you wear contact lenses?	NO	YES	UNKNOWN		
58. Does your back ever give you trouble?	NO	YES	UNKNOWN		
59. What do you usually take for a headache or other pain?					
<u>WOMEN ONLY</u> (men go to question 69)					
60. Are you pregnant?	NO	YES	UNKNOWN		
61. Are you anticipating becoming pregnant?	NO	YES	UNKNOWN		
62. Are you nursing?	NO	YES	UNKNOWN		
63. Have you ever had a miscarriage?	NO	YES	UNKNOWN		
64. Do you have any problems associated with your menstrual period?	NO	YES	UNKNOWN		
65. Are you in or have you passed through menopause (change of life)?	NO	YES	UNKNOWN		
66. Have you had a hysterectomy or other female surgery?	NO	YES	UNKNOWN		
67. Do you take birth control pills or hormones?	NO	YES	UNKNOWN		
68. Do you have any disease, condition or problem not listed above that you think I should know about? If yes, please explain.	NO	YES	UNKNOWN		
<u>DIET</u>					
69. Please check if you eat the following daily?					
- <i>meat</i>	NO	YES	- <i>fruits</i>	NO	YES
- <i>vegetables</i>	NO	YES	- <i>grain/cereal</i>	NO	YES
- <i>milk/other dairy products</i>	NO	YES	- <i>eggs</i>	NO	YES

70. Do you eat breakfast, lunch, and dinner?	NO	YES	If no, which?
71. Are you on or have you ever been on a special diet?	NO	YES	If yes, What for?
72. Do you drink some form of alcohol daily?	NO	YES	If yes, how much?

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change, I will inform the doctor.

Signature _____ Date _____

Comments:

Form B
GENERAL INFORMATION

THE FOLLOWING INFORMATION IS CONFIDENTIAL AND FOR OUR RECORDS ONLY.

Date _____

Patients Name _____

Sex _____ Weight _____ Height _____ Date of Birth _____ Age _____

Marital Status _____ Spouse's Name _____

Social Security # _____ Spouses Social Security # _____ Date of Birth _____

Residence Address _____
Street City State Zip

How long have you lived there? _____

Telephone _____

Employed by _____

Position _____

Business Address _____

Business Telephone _____

Spouse Employed by _____

Business Address _____

Name of Dentist _____

How long have you been under his/her care? _____

Name and Address of Physician (Medical Doctor) _____

Physician's (Medical Doctor) Telephone _____

Who may we thank for referring you to this office? _____

Why were you referred to a periodontist? _____

Are you covered by dental insurance? _____

Name and Address of Carrier _____

_____ Policy Number _____

Person Responsible for This Account _____

Person to Notify in Case of Emergency _____

GENERAL HEALTH

Circle One

- What is your estimation of your general health? GOOD – FAIR – POOR
- Yes No Are you now under the regular care of a physician?
If so, for what? _____
When was your last physical examination? _____
- Yes No Have you had any major operations, hospitalization or illnesses?
If so, for what? _____
- Yes No Are you taking any pills, medication or drugs?
If so, please list. _____
- Yes No Have you had any unusual reaction or allergies to any medications or foods?
If so, please list. _____

- Have you ever had a reaction to any of the following: (PLEASE CHECK)
- | | |
|--|--|
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Sleeping pills (Barbiturates) |
| <input type="checkbox"/> Sulfa drugs | <input type="checkbox"/> Tetracycline |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Dental anesthetic (Novocaine) |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Nitrous Oxide (Laughing Gas) |
| <input type="checkbox"/> Bisphosphonates | |

- Yes No Do you smoke?
- Yes No Do you drink alcohol?
- Yes No Are you on a diet of any kind?
- Yes No Has any member or your family had tuberculosis, diabetes, heart disease, allergies, bleeding problems or cancer? If yes, who? _____

- Do you have or have you ever had: (PLEASE CHECK)
- | | |
|---|---|
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Painful or frequent urination |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Ulcers (stomach or duodenal) |
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Kidney or bladder trouble |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> High or low blood pressure |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Thyroid or parathyroid disease |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Asthma or difficulty breathing |
| <input type="checkbox"/> Abnormal thirst | <input type="checkbox"/> Anemia or other blood disorder |
| <input type="checkbox"/> Tumors or growths | <input type="checkbox"/> Frequent vomiting or diarrhea |
| <input type="checkbox"/> X-ray or radiation therapy | <input type="checkbox"/> Arthritis or rheumatism |
| <input type="checkbox"/> Problems in healing | <input type="checkbox"/> Painful or swollen joints |
| <input type="checkbox"/> Frequent headaches | <input type="checkbox"/> Rashes or skin disorders |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Dizziness or light headaches |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Frequent fractures or dislocations | <input type="checkbox"/> Sexually related disease |
| <input type="checkbox"/> Condition requiring cortisone or other steroids | |
| <input type="checkbox"/> Hepatitis, jaundice or other liver disease | |
| <input type="checkbox"/> Shortness of breath or chest pains upon exertion | |
| <input type="checkbox"/> Tuberculosis, emphysema or other lung disease | |
| <input type="checkbox"/> Epilepsy, seizures, convulsions or fainting spells | |
| <input type="checkbox"/> Swelling of the hands, feet or eyes | |

- Yes No Are you excessively nervous or depressed?
- Yes No Have you ever been treated for nervous or mental disorders?
- Yes No Do you find it necessary to sleep using two pillows?
- Yes No Have you recently gained or lost excessive amounts of weight?
- Yes No Have you had abnormal bleeding after a cut or a tooth extraction?

WOMEN ONLY:

- Yes No Are you pregnant?
- Yes No Are you taking birth control pills?
- Yes No Do you have menstrual problems?
- Yes No Have you reached menopause (Change of Life)?

DENTAL HEALTH

- Yes No Do you consider yourself in good dental health?
- Yes No Do you think that your teeth are affecting your health in any way?
- Yes No Are you dissatisfied with the appearance of your teeth?
- Yes No Are you dissatisfied with your chewing ability?
- Have you ever had:
 - ___ Orthodontic treatment (Braces)
 - ___ Oral Surgery (Extraction, etc.)
 - ___ Periodontal treatment
 - ___ Your teeth ground or bite adjusted
 - ___ A bite plate or other appliance
- Yes No Have you noticed any loosening of your teeth?
- Yes No Does food tend to become caught between your teeth?
- Yes No Do you suffer from pain and/or swelling of your gums?
- Yes No Do your gums often bleed when you brush your teeth?
- Yes No Do you have any unpleasant odor or taste in your mouth?
- Yes No Are you missing any teeth?
 - Reasons: Decay () Gum Disease () Other ()
- Yes No Have missing teeth been replaced?
- Yes No Do you ever had any soreness, pain, clicking or popping in the area in front of your ears?
 - Do you:
 - ___ Clench or grind your teeth while awake or asleep
 - ___ Bite your lips or cheeks regularly?
 - ___ Hold foreign objects with your teeth?
 - ___ Breath primarily through your mouth?

When did you last have your teeth cleaned before this appointment? _____
 How long before that? _____
 How often do you see your dentist? _____
 How often and when do you brush your teeth? _____
 Do you use: Hand tooth brush () Electric toothbrush ()
 Is your toothbrush: Soft () Medium () Hard ()
 What else do you use to clean your teeth? (floss, toothpick, waterpick, etc.) _____
 How often? _____
 Yes No Do you feel apprehensive when you are having a dental treatment?
 Yes No Would you like to use nitrous oxide (laughing gas)?
 Yes No Does the fear of pain make you postpone your dental treatment?
 Yes No Is it important to you to keep your teeth?
 Yes No Would you spend fifteen minute a day in order to keep your natural teeth?

CONSENT FOR TREATMENT

I herby authorize Dr. _____ and whomever he may designate to perform the following procedure previously discussed: _____ and to administer emergency care as he deems necessary. I agree to the use of local anesthetic. I have been informed of possible complications from the above dental procedures.

Name of Patient or Legal Guardian

Date

Form C

Periodontics

Name First, Middle, Last Sex Birth Date Marital Status

Address (Street, City, State, Zip Code) Soc. Sec. No.

Home Phone Office Phone Business Name and Address

Dentist's Name Referred to this office by Occupation

Person Responsible for Payment of Account Relation Phone

Address

DENTAL INSURANCE INFORMATION

Primary Insurance Company

Name & Address Subscriber Soc. Sec. No.

Subscriber's Name Group or Company Name

Group Number Patient Relationship to Subscriber (self, spouse, child, etc.)

Secondary Insurance Company

Name & Address Subscriber Soc. Sec. No.

Subscriber's Name Group or Company Name

Group Number Patient Relationship to Subscriber (self, spouse, child, etc.)

MEDICAL HISTORY

Medical Doctor's Name

Address

Phone

Date of My Last Physical Examination

Results:

Are you being treated by a medical doctor now? If yes, for what reason?

Are you taking any medicine at the present time? If yes, what?

Are you sensitive or allergic to any medicine? If yes, what?

Have you ever been hospitalized or had any surgical operations? If yes, list reasons and dates

Have you ever had any blood transfusions? If yes, give reason

Have you had:

- | | | | | | |
|------------------------------|-----------------------------|---|------------------------------|-----------------------------|------------------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | HIV Positive | <input type="checkbox"/> Yes | <input type="checkbox"/> No | High Blood Pressure |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Gall Bladder Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | AIDS |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Low Blood Pressure | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Diabetes (Sugar Disease) |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Asthma | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Stroke |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Nervousness | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hay Fever |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Anemia | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Epilepsy or Seizures |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tuberculosis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Allergies or Hives |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Fainting or Dizzy Spells | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Rheumatic Fever |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Ulcers (stomach or intestinal) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Pacemaker |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Scarlet Fever | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Arthritis |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Thyroid Disease (or Goiter) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Heart Murmur |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Venereal Disease
(Syphilis or Gonorrhea) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | X-Ray or Cobalt Treatment |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Psychiatric Treatment | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Heart Disease |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Kidney Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Angina Pectoris |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hepatitis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Chemotherapy
(Cancer, Leukemia) |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Bladder Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Osteoporosis or Osteopenia |
-
- Yes No Do you have pain in the chest upon exertion
- Yes No Do you have shortness of breath after mild exercise?
- Yes No Do you use extra pillows to sleep?
- Yes No Do your ankles swell?
- Yes No Do you bruise easily?
- Yes No Have you ever had Yellow Jaundice?
- Yes No Do you have to urinate (pass water) more than 6 times a day?
- Yes No Are you thirsty much of the time?
- Yes No Does your mouth frequently become dry?
- Yes No Have you lost or gained weight (more than 10 pounds) in the past year?

- Yes No Are you following a diet?
 - Yes No Do you have Cataracts or Glaucoma?
 - Yes No Do you have difficulty swallowing?
 - Yes No Has a doctor ever said you have cancer or a tumor?
 - Yes No Have you ever had excessive bleeding from a cut or wound?
 - Yes No Do you have frequent severe headaches?
 - Yes No DO you worry a great deal?
 - Yes No Are you under abnormal stress? (For example marital, business, or social)
 - Yes No Do you feel you need psychiatric care or advice?
 - Yes No Do you sometime take medicine to relieve nervousness?
- Do you have any disease, condition or problem not listed above?
 If yes, explain: _____

Females

- Yes No Do you have trouble with your periods? (If you do not menstruate answer no)
- Yes No Did you have any complication during pregnancy (if you have never been pregnant answer no)
- Yes No Are you pregnant? (Date of delivery _____)
- Yes No Are you taking oral contraceptives (Birth control pills?)

Dental History

- Yes No Have you had any serious trouble associated with any previous dental treatment?
 If yes, explain: _____
- Yes No Do you bleed excessively, after tooth extraction?
- Yes No Have you recently had dental x-rays? If yes, when: _____
- Yes No Have you had undesirable reaction to local or general anesthetics
 (For example, Novocain or Gas)
- Yes No Do you clench or grind your teeth?
- Yes No Are any of your teeth sensitive to cold or sweets?
- Yes No Are you dissatisfied with the appearance of your teeth?
- Yes No Have you had excessive swelling or pain after oral surgery?
- Yes No Have your teeth been cleaned recently?
- Yes No Do you have bleeding gums?
- Yes No Do you have a bad taste in your mouth?
- Yes No Does food pack between your teeth?
- Yes No Does your jaw click or pop when you chew?
- Yes No Have you ever received treatment for periodontal disease?
- Yes No Has a dentist ever ground your teeth to correct your bite?
- Yes No Are you willing to become actively involved in the treatment of your periodontal disease

Briefly state your feelings toward dentures: _____

What is your chief complaint concerning your mouth or teeth? _____

To the best of my knowledge all of the above answers are true and correct. If I have any change in my health, I will inform Dr. _____ at my next appointment.

 Signature of Patient

 Date