METRO WEST DENTAL
SPECIALTY GROUP
PERIO. ORTHO. & DENTAL IMPLANT SOLUTIONS

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Patient Information

Date _____ Date of Birth_____

Patient's Name_____ E-mail_____

Home Address_____ Home Phone_____ Cell Phone_____

City_____ State_____ Zip_____

Patient's Employer_____ Soc. Sec. No _____

Patient's Occupation_____ Address _____ Phone _____

Spouse's Name_____ Spouse's Occupation _____

Spouse's Employer_____ Address _____ Phone _____

In Cae of Emergency Contact_____ Address_____ Work Phone_____ Home Phone_____

The reason for your visit today_____

Who referred you to our office?_____

Have we treated any of your friends or family?_____ Who?_____

IF YOU HAVE DENTAL INSURANCE, PLEASE COMPLETE THE FOLLOWING (IF TWO POLICIES; COMPLETE BOTH PORTIONS).

Primary Policy Holder _____
Insured Person _____
SS#_____ DOB _____
ID# _____ DL# _____
Employer _____
Name of Insurance Co. _____
Group# _____
Address (Insurance) _____
Phone (Insurance) _____

Secondary Policy Holder _____
Insured Person _____
SS#_____ DOB _____
ID# _____ DL# _____
Employer _____
Name of Insurance Co. _____
Group# _____
Address (Insurance) _____
Phone (Insurance) _____

MEDICAL HEALTH HISTORY

Periodontal disease is caused by a combination of complex factors and successful treatment depends upon their identification. the following questions are pertinent to the treatment of your periodontal condition. Please answer all questions. Circle yes or no, whichever applies. All answers are confidential. If you have a heart murmur, you must be screened for the need to pre-medicate prior to treatment, including the periodontal examination.

1. How is your general health? _____
2. Date of last physical examination _____
3. Reason for last physical examination _____
4. Physician's name _____

5. Are you being treated by a ❑ physician, or a ❑ psychiatrist now?
   If so explain_____
6. Have you ever been ❑ seriously ill, or ❑ hospitalized?
   If so explain_____
8. Are you taking any drugs or medications? If yes, please check the appropriate box

❑ antibiotics	❑ blood pressure medications	❑ hormones	❑ controlled substance
❑ anticoagulants	❑ cholesteral medications	❑ insulin	❑ other_____
❑ Aspirin (please note: Chronic aspirin consumption can cause bleeding problems.)	❑ cortisone (steroids)	❑ non-prescription medications	_____
❑ birth control pills	❑ heart medicine	❑ tranquilizers	_____

9. Women: Are you pregnant?/nursing..... Yes or No
10. Have you ever been given intravenous bisphosphonates? (❑ Zometa ❑ Aredia ❑ Benefus)
11. Have you ever taken oral or nose spray bisphosphonates? (❑ Actonel ❑ Skelid ❑ Didronel ❑ Fosamax ❑ Boniva ❑ Miacalcin
12. Have you ever had a serious infectious disease? (❑ Hepatitis ❑ Tuberculosis ❑ Syphilis
13. Have you noticed any swollen glands or nodes? ..... Yes or No
14. Have you had abnormal bleeding associated with extractions, surgery, or menstration?..... Yes or No
15. Do you have, or have you had any of the following? (Check all boxes that apply)

❑ AIDS/HIV Positive	❑ Chest Pains	❑ Genital Herpes	❑ Kidney Problems	❑ Shingles
❑ Alzheimer's Disease	❑ Cold Sores/Fever Blisters	❑ Glaucoma	❑ Leukemia	❑ Sickle Cell Diseases
❑ Anaphylaxis	❑ Congenital Heart Disorder	❑ Hay Fever	❑ Liver Disease	❑ Sinus Trouble
❑ Anemia	❑ Cortisone Medicine	❑ Heart Attack/Failure	❑ Low Blood Pressure	❑ Spina Bifida
❑ Angina	❑ Depression	❑ Heart Murmer	❑ Lung Disease	❑ Stomach/Intestinal Disease
❑ Arthritis/Gout	❑ Diabetes	❑ Heart Pacemaker	❑ Mitral Valve Prolapse	❑ Stroke
❑ Artificial Heart Valve	❑ Drug Addiction	❑ Heart Trouble/Disease	❑ Osteoporosis	❑ Swelling of Limbs
❑ Artificial Joint	❑ Easily Winded	❑ Hemophilia	❑ Pain in Jaw Joints	❑ Thyroid Disease
❑ Asthma	❑ Emphysema	❑ Hepatitis A	❑ Parathyroid Disease	❑ Tonsillitis
❑ Blood Disease	❑ Epilepsy or Seizures	❑ Hepatitis B or C	❑ Psychiatric Care	❑ Tuberculosis
❑ Bi Polar	❑ Excessive Bleeding	❑ Herpes	❑ Radiation Treatments	❑ Tumors or Growths
❑ Blood Transfusion	❑ Excessive Thirst	❑ High Blood Pressure	❑ Recent Weight Loss	❑ Ulcers
❑ Breathing Problem	❑ Fainting Spells/Dizziness	❑ High Cholesterol	❑ Renal Dialysis	❑ Venereal Disease
❑ Bruise Easily	❑ Frequent Cough	❑ Hives or Rash	❑ Rheumatic Fever	❑ Yellow Jaundice
❑ Cancer	❑ Frequent Diarrhea	❑ Hypoglycemia	❑ Rheumatisim	❑ Other _____
❑ Chemotherapy	❑ Frequent Headaches	❑ Irregular Heartbeat	❑ Scarlet Fever	

PLEASE COMPLETE REVERSE SIDE

16. Are you allergic or have you experienced an unusual reaction to any drugs? ..... Yes or No

- ❑ aspirin
- ❑ barbiturates or sedatives
- ❑ codeine
- ❑ dental anesthetic
- ❑ erthromycin
- ❑ penicillin
- ❑ sulfa drugs
- ❑ tetracycline
- ❑ other antibiotics
- ❑ other_____

17. Are you on a special diet? ..... Yes or No
18. Do you use tobacco? ..... Yes or No
19. Do you drink alcholic beverages? ..... Yes or No
20. Do you use controlled substances? ..... Yes or No
21. Have you ever had an alcohol or drug related problem? ..... Yes or No
22. Is there a tendency towards any illness in your family? ❑ diabetes ❑ heart trouble ❑ Other_____
23. Do you have any disease, condition, or problem not listed that I should know about? ..... Yes or No

If so explain _____

DENTAL HEALTH HISTORY

Circle Yes or No

1. Are you aware of any problem with the gum or bone around your teeth?_____What?_____
2. Who is your regular dentist? _____
3. Has your dental care been: ❑ Regularly (yearly) ❑ Intermittent (when necessary) ❑ Infrequent (when in pain)
4. When was the last time for teeth cleaning?_____
5. Have you ever had Periodontal Care? Yes or No When?_____ Orthodontic care? Yes or No When?_____
6. Did your mother, father, brother or sister lose all of their natural teeth? Yes or No How?_____
7. Would you be very disturbed if you had to lose your teeth and wear false teeth? ..... Yes or No
8. Are you dissatisfied with the appearance of your teeth? ..... Yes or No
9. How often do you brush your teeth?_____ Floss your teeth?_____
10. Have you ever experienced any of the following?
    - ❑ bleeding gums
    - ❑ swelling gums
    - ❑ pain or soreness in gums
    - ❑ receding gums
    - ❑ pus around teeth
    - ❑ loose teeth
    - ❑ spaces between teeth
    - ❑ drifting teeth
    - ❑ jaw pain (TMD)
    - ❑ foul odor
    - ❑ bad breath or bad taste
    - ❑ food packing between teeth
    - ❑ high or rough fillings
11. Do you often have fever blisters on your lips? Yes or No After dental work? ..... Yes or No
12. Is there sensitivity in your teeth?
    - ❑ hot
    - ❑ cold
    - ❑ sweet
    - ❑ biting
    - ❑ tooth brushing
    - ❑ pressure
13. Have you ever had an injury to your face, neck, or jaw? ..... Yes or No
14. Do you suffer from pain in the face, neck, or jaw? ..... Yes or No
15. Do you grind your teeth? Yes or No Do you clench or clamp your teeth? ..... Yes or No
16. Have you ever had a bad experience in a dental office? Please explain_____
17. What are major concerns with regards dental treatment?
    - ❑ esthetics
    - ❑ quality of life
    - ❑ jaw function
    - ❑ bite
    - ❑ finance
    - ❑ other

These statements are true and complete to the best of my knowledge.

_____ _____
Signature of Patient, Parent or Guardian Date

Pleas be advised that 24-hour notice of inability to keep your appointment is expected, otherwise a reasonable fee for time lost will be charged. In addition we advise all patients to visit a general dentist for a decay examination annually.

_____ _____
Doctor's Signature Date