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Practice Limited to Periodontics TELEPHONE: (248) 357-3100

PLEASE PRINT

REGISTRATION

Date _____

Patient's Name _____ Circle: Dr. – Mr. – Mrs. – Ms.

Residence Address _____

City _____ State _____ Zip Code _____

Telephone: Residence _____ Business _____ Cell _____

Email Address _____ ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Minor

Date of Birth _____ Social Security No. _____ Age _____ Height _____ Weight _____

Employed by _____ Occupation _____

Business Address _____

If a Child, Parent's Name _____

Name of Spouse _____

Spouse Employed by _____ Occupation _____

Spouse's Date of Birth _____ Spouse's Social Security No. _____ Business Phone No. _____

Referred by _____

Name and Address of General Dentist _____

_____ Phone _____

Emergency Contact (name, address, phone no.) _____

_____

Person Responsible for Payment of Account (and address if different from above) _____

_____

Pharmacy Name _____ Phone _____

Name of Dental Insurance Company _____

Name of Medical Insurance Company _____

Spouse's Dental Insurance Company _____

Spouse's Medical Insurance Company _____

HEALTH QUESTIONNAIRE

Answers to the following questions are for our records and will be considered *confidential*.

1. Are you presently under the care of a physician? Yes No

   If so, for what condition are you being treated? _____

   _____

   _____

   Name and address of physician _____

   _____

   _____ Phone _____

2. Is your general health good? Yes No
3. Have you ever been hospitalized or had a serious illness? Yes No

   Explain _____
4. Have you had abnormal bleeding associated with previous extractions, surgery, or trauma? Yes No

   a. Do you bruise easily? Yes No

   b. Have you ever required a blood transfusion? Yes No

   If so, please explain the circumstances. _____

   _____
5. What drugs are you allergic to or have you reacted adversely to? _____

   _____
6. Have you had any trouble with previous dental work? Yes No

   Please explain _____

   _____
7. Have you ever had a malignant or non-malignant tumor removed? Yes No
8. Do you wear a pacemaker? Yes No
9. Are you pregnant? Yes No
10. Do you wear or have you worn a removable dental appliance or night guard? Yes No

Please Complete Reverse Side

Do you have or have you ever had?

Heart trouble	Yes	No
Pain in chest	Yes	No
Shortness of breath	Yes	No
Swollen ankles	Yes	No
Rheumatic fever	Yes	No
Heart murmur	Yes	No
Mitral valve prolapse (MVP)	Yes	No
Fainting or dizziness	Yes	No
Stroke	Yes	No
High blood pressure	Yes	No
Diabetes	Yes	No
Bad nose bleeds	Yes	No
Rheumatic heart disease	Yes	No
Anemia	Yes	No
Epilepsy or convulsions	Yes	No
Thyroid trouble	Yes	No
Low blood pressure	Yes	No
Multiple sclerosis	Yes	No
Lupus	Yes	No
Asthma	Yes	No
Tuberculosis	Yes	No
Kidney or liver trouble	Yes	No
Neurosis or psychological problems	Yes	No
Hepatitis A, B or C	Yes	No
Prolonged bleeding	Yes	No
Stomach trouble	Yes	No
Venereal disease: Herpes	Yes	No
HIV, AIDS	Yes	No
Arthritis	Yes	No
Cancer	Yes	No

Do you take on a regular basis?

Ecotrin, Motrin, **Aspirin**, Aleve, Ibuprofen	Yes	No
Anticoagulants	Yes	No
Antibotics	Yes	No
(If yes, name) _____		
Antihistamines	Yes	No
Drugs for high blood pressure	Yes	No
Insulin	Yes	No
Vitamin E	Yes	No
Ginkgo biloba	Yes	No
St. John's Wort	Yes	No
Bilbery	Yes	No
Melatonin	Yes	No
Echinacea	Yes	No
Ginseng	Yes	No
Fish oil	Yes	No
Garlic	Yes	No

Do you use a CPAP machine at night? Yes No

What medications are you taking? _____

Do you take aspirin daily? Yes No

Do you have any condition, problem, or disease not mentioned above?_____

Please explain _____

Is there anything else about your health or health history that might affect your dental care? _____

THE FOLLOWING IMPORTANT HISTORY IS NECESSARY FOR YOUR PERIODONTAL DIAGNOSIS AND TREATMENT PLANNING

Why are you here? _____

Who is your general dentist? _____ When were your teeth last cleaned? _____

Are you currently experiencing pain from your mouth?	Yes	No
Explain _____		
_____		
Have you ever had periodontal treatment?	Yes	No
Have you completed any recent dental procedures?	Yes	No
What?_____		
_____		
Do you fear dental treatment?	Yes	No
Can you chew satisfactorily?	Yes	No
Are you embarrassed by bad breath?	Yes	No
Have you noticed any bad oral odors or taste?	Yes	No
Have you ever had a tooth or gum abscess?	Yes	No
Do you wear or have you worn a removable dental appliance?	Yes	No
Are your teeth sensitive to hot or cold drinks, sweets, chewing, or touch?	Yes	No
Have you noticed bleeding during brushing, flossing, or eating?	Yes	No
Do you have any loose teeth?	Yes	No
Are your gums receding?	Yes	No
Do you ever awaken with "tightness" or pain in the jaw joints?	Yes	No
Do your jaw joints pop or click?	Yes	No
Do you clench or grind your teeth at night or during the day?	Yes	No
Have you noticed your bite changing or any teeth moving?	Yes	No
Do you smoke?	Yes	No
Are your teeth affecting your general health in any way?	Yes	No

Patient's Signature _____ **Date** _____