

# ELITE PERIODONTAL & IMPLANT CARE

2365 Boston Post Road, Suite 104 Larchmont, NY 10538



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.

Name \_\_\_\_\_ Today's Date \_\_\_\_\_

Birth Date \_\_\_\_\_ Social Security # \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Age \_\_\_\_\_ Sex \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Occupation \_\_\_\_\_

Married \_\_\_\_\_ Single \_\_\_\_\_ Spouse's Name \_\_\_\_\_

Closest Relative \_\_\_\_\_ Phone Number \_\_\_\_\_

**Primary Physician** \_\_\_\_\_ Address \_\_\_\_\_

Phone \_\_\_\_\_

Last Physical Examination \_\_\_\_\_

**Primary Dentist** \_\_\_\_\_ Address \_\_\_\_\_

Phone \_\_\_\_\_

Last Dental Treatment \_\_\_\_\_ Procedure \_\_\_\_\_

**Referred By** \_\_\_\_\_

Give your reason(s) for seeking periodontal treatment

**Dental Insurance Information:**

Insurance Carrier Name \_\_\_\_\_ Insurance phone number \_\_\_\_\_

Insurance Group Number \_\_\_\_\_

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

1. Are you experiencing pain from your mouth at this time?	NO	YES	UNKNOWN	Where?
2. Have you ever had periodontal (gum) treatment? When? _____ When? _____ Doctor _____	NO	YES	UNKNOWN	
3. Did either of your parents lose all their natural teeth?	NO	YES	UNKNOWN	
4. Do you smoke?	NO	YES	UNKNOWN	What? _____ How much? _____
5. Are you aware of clenching, gritting, or grinding your teeth?	NO	YES	UNKNOWN	While awake? While asleep?
6. Are you in good health?	NO	YES	UNKNOWN	When?

7. Has there been any change in your general health within the past year?	NO	YES	UNKNOWN	Which area?
8. Are you under the care of a physician?	NO	YES	UNKNOWN	What for?
9. Have you ever had a major illness or operation?	NO	YES	UNKNOWN	What for?
10. Have you ever had any problems with surgery or anesthesia?	NO	YES	UNKNOWN	What?
11. Have you ever been hospitalized?	NO	YES	UNKNOWN	
<b>12. Do you have or have you had any of the following diseases or conditions?</b>				
- rheumatic fever or rheumatic heart disease	NO	YES	- pacemaker	NO YES
- Sinus or Nasal problems	NO	YES		
- congenital heart problem (murmur, MVP)	NO	YES	- AIDS/HIV positive	NO YES
- heart attack	NO	YES	- arthritis	NO YES
- rheumatism (painful, swollen joints)	NO	YES	- stroke	NO YES
- hepatitis, jaundice or liver disease	NO	YES	- stomach ulcers	NO YES
- high blood pressure	NO	YES	- kidney trouble	NO YES
- low blood pressure	NO	YES	- tuberculosis	NO YES
- persistent cough or cough up blood	NO	YES	- arteriosclerosis	NO YES
- chest pain or exertion	NO	YES	- venereal disease	NO YES
- psychiatric treatment/counseling	NO	YES	- bypass surgery	NO YES
- shortness of breath	NO	YES	- anemia	NO YES
- swollen ankles	NO	YES	- glaucoma	NO YES
- hives or skin rash	NO	YES	- thyroid trouble	NO YES
- fainting spells or seizures (epilepsy)	NO	YES	- porphyria	NO YES
- illness that lasted more than one week	NO	YES	- Diabetes	NO YES
- Other	NO	YES	- allergy	NO YES
<b>Please list any allergies, including allergies to medications:</b>				
<b>13. Are you presently taking or have you taken any of the following drugs or medications within the past year?</b>				
- antibiotics or sulfa drugs	NO	YES	- tranquilizers	NO YES
- anticoagulants (blood thinners)	NO	YES	- sleeping pills	NO YES
- medicine for high blood pressure	NO	YES	- vitamins	NO YES
- cortisone (steroids)	NO	YES	- aspirin	NO YES
- marijuana or other recreational drugs	NO	YES	- hormones	NO YES
- medication you purchase yourself without a prescription	NO	YES	- nitroglycerine	NO YES
- insulin, tolbutamide or similar drugs	NO	YES	- digitalis or similar drugs	NO YES
- other	NO	YES	- bisphosphonates	NO YES
14. Have you had abnormal bleeding with extractions, surgery, or trauma?	NO	YES	UNKNOWN	
15. Have you ever required a blood transfusion?	NO	YES	UNKNOWN	
16. Do you have any blood disorders?	NO	YES	UNKNOWN	
<b>WOMEN ONLY</b>	NO	YES	UNKNOWN	
17. Are you pregnant?	NO	YES	UNKNOWN	
18. Are you anticipating becoming pregnant?	NO	YES	UNKNOWN	
19. Are you nursing?	NO	YES	UNKNOWN	
20. Do you have any problems associated with your menstrual period?	NO	YES	UNKNOWN	
21. Are you in or have you passed through menopause ?	NO	YES	UNKNOWN	
22. Have you had a hysterectomy or other female surgery?	NO	YES	UNKNOWN	
23. Do you take birth control pills or hormones?	NO	YES	UNKNOWN	
24. 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	

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 \_\_\_\_\_

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