# 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 | |

**12. Do you have or have you had any of the following diseases or conditions?**

| | | | | | |
|---|---|---|---|---|---|
| *- 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 |

**Please list any allergies, including allergies to medications:**

13. Are you **presently taking** or **have you taken** any of the following drugs or medications within the past year?

| | | | | | |
|---|---|---|---|---|---|
| *- 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 | |
| **WOMEN ONLY** | 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 _____