WETZEL Periodontics & Dental Implants

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INFORMATION AND HEALTH HISTORY

Date

Patient's Name *(please print)*

Name You Prefer to be Addressed by

Address

City State Zip

Marital Status: ❑ Single ❑ Separated ❑ Married ❑ Divorced ❑ Widow

Sex: ❑ Male ❑ Female

Patient's Age

( ) Home Phone No.

Date of Birth

( ) Work Phone No.

Soc. Sec. No.

( ) Cell Phone No.

Email

Patient's Occupation

Patient's Employer

Employer's Address

Have you even been treated in our office before? ❑ Yes ❑ No

If so, when?

Your Dentist's Name

Address

( ) Phone No.

Referred by

Primary Dental Insurance

Fill out information below ONLY if you have dental insurance

Name of Insurance Company

Address

City State Zip

( ) Phone No.

ID/Agreement No. Group Name or No.

Subscriber's Name on insurance coverage *(if different from patient's)*

Date of Birth Soc. Sec. No.

Employer's Name

Address

How is the patient related to the employee?

❑ Subscriber ❑ Spouse ❑ Dependent

FINANCIALLY RESPONSIBLE PERSON IF OTHER THAN PATIENT

First Name Middle Init. Last Name

Address

City State Zip

Sex: ❑ Male ❑ Female

( ) Home Phone No.

Date of Birth

( ) Work Phone No.

Soc. Sec. No.

Occupation

Employer

Address

City State Zip

Family Physician

Address

( ) Phone No.

Emergency Contact Name Relationship

Emergency Contact Phone No.

Secondary Dental Insurance

Name of Insurance Company

Address

City State Zip

( ) Phone No.

ID/Agreement No. Group Name or No.

Subscriber's Name on insurance coverage *(if different from patient's)*

Date of Birth Soc. Sec. No.

Employer's Name

Address

How is the patient related to the employee?

❑ Subscriber ❑ Spouse ❑ Dependent

DATE OF LAST PHYSICAL EXAM ______________________________

Periodontal Disease is caused by a combination of complex factors and the following questions are designed to help us identify them. The success of therapy is dependent upon this. Therefore, although some of the following questions may seem unrelated to your periodontal condition, they are all associated with proper management of your oral condition and are held in strict confidence.

PLEASE CIRCLE YES OR NO

When answering yes, please list or circle appropriate condition/medication.

MEDICAL HISTORY

YES NO Are you presently under a physician's care? If so, for what: ______________________________

YES NO Have you ever been hospitalized? If so, for what: ______________________________

YES NO Has there been any change in your health in the past year?

YES NO Have you ever been advised to premedicate with **antibiotics** for dental appointments?

Are you allergic to or react adversely to:

YES NO Local Anesthetics (Novacain)

YES NO Motrin (Ibuprofen)

YES NO Aspirin

YES NO Barbiturates, sedatives, sleeping pills

YES NO Latex

YES NO Penicillin

YES NO Other antibiotics ______________

YES NO Codeine or other narcotics ______________

YES NO Other ______________

Do you have or have you had any of the following problems?

YES NO Hepatitis, jaundice, or liver disease

YES NO Heart murmur/Mitral valve prolapse/Rheumatic fever

YES NO Heart trouble or stroke

YES NO Do you wear a pacemaker?

YES NO Do you have a cardiac valve prosthesis?

YES NO High or low blood pressure

YES NO Chest pains, ankle swelling, or shortness of breath

YES NO Do you have prosthetic joints (Hips, knees, etc.)?

YES NO Asthma, allergies, respiratory problems

YES NO Epilepsy or seizures

YES NO Diabetes

YES NO Arthritis, rheumatism

YES NO Stomach or duodenal ulcers

YES NO Have you ever tested **positive** to the HIV Virus?

YES NO Medical radiation treatments

YES NO Glaucoma

YES NO Abnormal bleeding problems or blood disorders

YES NO Tuberculosis ______________

YES NO Sinus surgery ______________

YES NO Any other medical conditions? If yes, what: ______________________________

Are you presently taking any of the following medications?

YES NO Antibiotics ______________

YES NO Medication for high blood pressure ______________

YES NO Tranquilizers ______________

YES NO Aspirin ______________

YES NO Digitalis or other heart medication ______________

YES NO Anticoagulants (Blood thinners)

YES NO Cortisone (steroids)

YES NO Medication for Diabetes ______________

YES NO Nitroglycerin

YES NO Are you presently taking any other medication? If yes, please list: ______________________________

____

YES NO Have you ever taken **intravenous** medication to increase bone density (e.g., Zometa, Aredia)?

YES NO Do you use any tobacco products? How much______

WOMEN

YES NO Are you pregnant?

YES NO Do you take oral birth control medication?

YES NO Are you post-menopause?

DENTAL HISTORY

YES NO Are you in pain now?

YES NO Have you ever had treatment for periodontal disease?

YES NO Do your gums bleed?

YES NO Do your teeth feel loose?

YES NO Do you grind or clench your teeth or jaw during day or night?

YES NO Do you have sore or sensitive teeth?

YES NO Do you have pain elsewhere in your face or jaw?

How long have you known about your gum condition? ______________________________

YES NO Have you ever had your teeth straightened? (Orthodontics) If yes, when: ______________________________

How often do you brush your teeth? ______________________________

YES NO Do you use dental floss, toothpicks, water irrigation or other devices? If yes, how often: ______________________________

How often do you have your teeth cleaned: ______________________________

YES NO Do you wear dentures?

DATE ______________ SIGNATURE OF PATIENT ______________________________

UPDATE ______________ SIGNATURE ______________________________

UPDATE ______________ SIGNATURE ______________________________