NORTHERN PERIODONTICS & IMPLANT DENTISTRY

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MICHAEL R. DOCTOR, D.D.S., M.S.

Name ______________________ Home Phone ______________________ Work Phone ______________________

Address ______________________ City ______________________ State __________ Zip __________

Date of Birth __________ Social Security # ______________________ E-mail ______________________

Employer ____

Business Address ____

Name of Spouse ______________________ Spouse's Employer ______________________

Business Address ______________________ Business Phone ______________________

Dental Insurance (primary) ______________________ (secondary) ______________________

Name of Insured ______________ Social Security # ______________ Relationship to insured ________ D.O.B. ______

Physician ______________________ Address ______________________

Dentist ______________________ Address ______________________

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

Yes	No	
❑	❑	Do you consider yourself to be in good general health?
❑	❑	Are you presently or have you recently been treated by a physician for any condition? Please List: ______________________ ______________________ ______________________
❑	❑	Have you ever had a serious illness or operation? ______________________ ______________________
❑	❑	Have you lost or gained more than 10 pounds in the last year?
❑	❑	Do you use tobacco (smoking/chewing)? ___packs/day
❑	❑	Do you take aspirin or aspirin products on a regular basis?
❑	❑	Are you now taking any other medicines (drugs, vitamins, pills or herbs)?

Which?

1 __________ 5 __________

2 __________ 6 __________

3 __________ 7 __________

4 __________ 8 __________

Approximate date of your last physical examination: __________

Are you allergic or have you reacted adversely to any of the following?

YES	NO	
❑	❑	Local Anesthetic (Novacain)
❑	❑	Penicillin or any other antibiotic
❑	❑	Aspirin
❑	❑	Codeine
❑	❑	Iodine
❑	❑	Sulfa
❑	❑	Latex
❑	❑	Other ______________________ ______________________
❑	❑	Have you taken bisphosphonate medication (Fosamax, Boniva, Actonel, Zometa or Reclast) in the past?

WOMEN ONLY

❑	❑	Are you pregnant or nursing?
❑	❑	Are you taking birth control medication?
❑	❑	Have you undergone or are you undergoing menopause?

DENTAL HISTORY

Do you or have you had

YES	NO	
❒	❒	Rheumatic Fever
❒	❒	Heart Murmur
❒	❒	Mitral Valve Prolapse
❒	❒	Artificial Heart Valve
❒	❒	Congenital Heart Disease
❒	❒	Heart (surgery, disease, attack)
❒	❒	Artificial Joints (hip, knee, etc.)
❒	❒	Heart Pacemaker
❒	❒	Diabetes
❒	❒	Hepatitis A B C
❒	❒	AIDS, ARC, HIV Infection
❒	❒	High Blood Pressure
❒	❒	Low Blood Pressure
❒	❒	Chest Pain
❒	❒	Stroke
❒	❒	Osteoporosis/Osteopenia

YES	NO	
❒	❒	Radiation Therapy
❒	❒	Chemotherapy
❒	❒	Tumors
❒	❒	Arthritis/Rheumatism
❒	❒	Cortisone Medication
❒	❒	Diet (special restrictions)
❒	❒	Kidney Trouble
❒	❒	Ulcers
❒	❒	Thyroid Condition
❒	❒	Glaucoma
❒	❒	Emphysema
❒	❒	Chronic Cough
❒	❒	Tuberculosis (TB)
❒	❒	Asthma or Hay fever
❒	❒	Sleep Apnea

YES	NO	
❒	❒	Latex or Metal Sensitivity
❒	❒	Allergies or Hives
❒	❒	Sinus Trouble
❒	❒	Venereal Disease
❒	❒	Cold Sores or Fever Blisters
❒	❒	Blood Transfusion
❒	❒	Hemophilia
❒	❒	Bleeding Problems
❒	❒	Bruise Easily
❒	❒	Liver Disease
❒	❒	Neurological Disorders
❒	❒	Epilepsy or Seizures
❒	❒	Fainting or Dizzy Spells
❒	❒	Psychiatric/Psychological Care
❒	❒	Frequent Severe Headaches

How frequently do you visit your dentist? ____________________ Last Dental Cleaning__________

Name of previous dentist:______________________________

YES	NO	
❒	❒	Do your gums bleed or hurt?
❒	❒	Have any of your teeth recently separated, creating a space between them?
❒	❒	Does food wedge between any of your teeth? Where?______________

YES	NO	Have you ever had any of the following
❒	❒	Periodontal treatment? date: __________
❒	❒	Orthodontic treatment? date: __________
❒	❒	Your teeth ground or the bite adjusted? date: __________
❒	❒	A bite splint or mouth guard? date: __________
❒	❒	A serious injury to the mouth or head? Please describe __________

YES	NO	
❒	❒	Would you be greatly disturbed if you had to lose all your natural teeth?
❒	❒	Did either parent lose all of their natural teeth?
❒	❒	Are you dissatisfied with the appearance of your teeth? Why? __________

YES	NO	Do you:
❒	❒	Clench or grind your teeth while awake or asleep?

Is there anything else about having dental treatment that you would like us to know? If so, please describe.______________

YES	NO	Are any of your teeth sensitive to the following: __________
❒	❒	Hot or cold? Where? __________
❒	❒	Sweets? Where? __________
❒	❒	Biting or Chewing? Where? __________
❒	❒	Have you noticed any mouth odors or bad taste?

<u>I certify that the above information in the medical and dental history is true and accurate</u>

Patient's/Parent's Signature ______________________________ Date__________