Newhouse Periodontics

NEW PATIENT INFORMATION (Please Print) Date ____________________

Please answer the following questions completely. The information is for our records and is considered confidential.

Patient's name	Date of birth	Age	Social Security number	email address	Marital status
Spouse's name			Social Security number	email address	
If a child, parent's name			Social Security number		
Address (Street, City, State, Zip)				Home phone	
Employed by				Cell phone	
Employer's address (Street, City, State, Zip)				Business phone	
Spouse employed by				Business phone	
Spouse's employer address (Street, City, State, Zip)					
Nearest relative, not living with you (Street, City, State, Zip)				Relative's phone	
Person responsible for payment of account, if other than patient (Street, City, State, Zip)					
Dental Insurance provider	Policy number	Secondary provider, if applicable		Policy number	
Financial institutions you do business with					
Whom may we thank for referring you?					

HEALTH QUESTIONNAIRE (Answer all questions as completely as possible)

Yes No

❐ ❐ Are you presently under the care of a physician? If yes, for what condition?____________________

❐ ❐ Name, address and phone number of physician ____________________

❐ ❐ Is your general health good?

❐ ❐ Have you ever been hospitalized or had a serious illness? If yes, please explain ____________________

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❐ ❐ Have you had abnormal bleeding associated with previous extractions, surgery, or trauma?

❐ ❐ Do you bruise easily?

❐ ❐ Have you ever required a blood transfusion? If yes, explain the circumstances ____________________

Are you allergic or have you reacted adversely to:

❐ ❐ a. Local anesthetics?

❐ ❐ b. Penicillin or other antibiotics?

❐ ❐ c. Barbiturates, sedatives, sleeping pills?

❐ ❐ d. Aspirin?

❐ ❐ e. Codeine or other narcotics?

❐ ❐ f. Nitrous oxide analgesia ("laughing gas")?

❐ ❐ g. Have you had an unpleasant experience with any gas administered to you?

❐ ❐ Have you had any trouble with previous dental work? If yes, please explain ____________________

❐ ❐ Do you consider yourself a nervous or tense person?

❐ ❐ Have you ever had a malignant or non-malignant tumor removed?

❐ ❐ Have you ever had a biopsy?

❐ ❐ Do you wear a pacemaker?

❐ ❐ Do you smoke? If yes, how much? ____________________

❐ ❐ Are you HIV positive?

❐ ❐ Have you ever been tested for Human Immunodeficiency Virus?

Women:

❐ ❐ Are you pregnant?

❐ ❐ Are you presently taking birth control pills?

Please continue on second page

Do you or have you ever had: (check all that apply)

Yes	No	
❐	❐	Heart Trouble
❐	❐	Epilepsy or convulsions
❐	❐	Prolonged bleeding
❐	❐	Rheumatic Fever
❐	❐	Low blood pressure
❐	❐	Measles
❐	❐	High blood pressure
❐	❐	Kidney or bladder trouble
❐	❐	Cancer
❐	❐	Anemia
❐	❐	Hepatitis (If yes, which type? _________)
❐	❐	Swollen ankles

Yes	No	
❐	❐	Goiter
❐	❐	Arthritis
❐	❐	Stroke
❐	❐	Tuberculosis
❐	❐	Frequent headaches
❐	❐	Rheumatic heart disease
❐	❐	AIDS
❐	❐	Jaundice
❐	❐	Shortness of breath
❐	❐	Thyroid trouble
❐	❐	Venereal disease (If yes, what disease? _________________________________)

Yes	No	
❐	❐	Fainting or dizziness
❐	❐	Hayfever or Asthma
❐	❐	Eczema or Hives
❐	❐	Bad nose bleeds
❐	❐	Glaucoma
❐	❐	Stomach trouble
❐	❐	Heart Murmur
❐	❐	Persistant cough
❐	❐	Tumor
❐	❐	Diabetes (If yes, which type? _________)

Have you ever taken: (check all that apply)

Yes	No	
❐	❐	Aspirin
❐	❐	Drugs for high blood pressure
❐	❐	Antihistamines
❐	❐	Nitroglycerin
❐	❐	Insulin or Ornase

Yes	No	
❐	❐	Cortisone, steroids, ACTH
❐	❐	Sulfa drugs
❐	❐	Tranquilizers or sedatives
❐	❐	Anticoagulants
❐	❐	Digitalis or drugs for heart trouble

Yes	No	
❐	❐	Drugs for sleep
❐	❐	Antibiotics
❐	❐	Penicillin

What medications have you taken in the past year? ____

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Do you have any condition, problem or disease not mentioned above? If yes, please explain. ______________________________

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

Why are you here? ____

Who is your general dentist? ______________________________ For how many years? ___________

When did you see your dentist last? ______________________ When were your teeth last cleaned? ______________________

How often are your teeth cleaned? ____

Yes	No	
❐	❐	Are you currently experiencing pain from your mouth?
❐	❐	Have you ever had periodontal treatment?
❐	❐	Has periodontal disease been found in your mouth before?
❐	❐	Have you completed any recent dental procedures? If yes, what? ______________________________
❐	❐	Do you fear dental treatment?
❐	❐	Have you had any teeth extracted recently?
❐	❐	Can you chew satisfactorily?
❐	❐	Have you had many cavities?
❐	❐	Are you satisfied with the appearance of your teeth?
❐	❐	Have you noticed any bad oral odors or tastes?
❐	❐	Have you ever had trench mouth?
❐	❐	Have you ever had a tooth or gum abscess?
❐	❐	Are your teeth sensitive to hot, cold, sweets, chewing, or touch?
❐	❐	Have you noticed any rough, sharp or uneven fillings?
❐	❐	Have you had any change in the ability to catch or wedge food between
❐	❐	Have you noticed bleeding during brushing, flossing, or eating?
❐	❐	Do you have any loose teeth?

Yes	No	
❐	❐	Are your gums receding?
❐	❐	Do you clench or grind your teeth at night or during the day?
❐	❐	Have you noticed your bite changing or any teeth moving? If yes, how long? ______________________________
❐	❐	Have you noticed increasing spaces between teeth?
❐	❐	Do your teeth come together unevenly?
❐	❐	Do you ever awaken with “tightness” or pain in the jaw joints?
❐	❐	Do your jaw joints hurt after eating, talking, yawning or a long day?
❐	❐	Do your jaw joints pop or click?
❐	❐	Do you take vitamins or diet supplements?
❐	❐	Do you have an imbalanced or irregular diet?
❐	❐	Are you frequently dieting?
❐	❐	Do you eat many sweets or drink colas, coffee, or tea with sugar?
❐	❐	Do you use breath mints, “Lifesavers,’ “Clorets,” “Certs,” “Tic Tacs,” chewing gum or hard candies?
❐	❐	Do you regularly use “Tums,” “Rolaids,” or other antacids?
❐	❐	Do you wake up with a dry mouth or lips?
❐	❐	Have you experienced a burning sensation of the tongue?
❐	❐	Are your teeth affecting your general health in any way?

Please note any items you use in your mouth care and frequency: ❐ Toothbrush ❐ Floss ❐ Waterspray device ❐ Toothpicks ❐ Proxabrush ❐ Stimudents ❐ Rubber tip ❐ Mouthwashes ❐ Electric toothbrush ❐ Other ______________________________

Patient’s Signature ______________________________ Date ______________

Periodontist’s Signature ______________________________ Date ______________