Periodontal Patient Information Questionnaire

Coast Periodontics & Laser Surgery • Dr. Lynn C. Sayre-Carstairs, DMD, Inc. • forms@coastperiodontics.com

Patient Name: _____ How would you like to be addressed: _____

Age: _____ Date of Birth: _____ ☐ Male ☐ Female ☐ Single ☐ Married ☐ Other ☐ Minor

Mailing Address: _____ City: _____ St: _____ Zip: _____

Home Phone: (____)____-_____ x_____ Alternate Phone: (____)____-_____ x_____ Bus. Phone: (____)____-_____ x_____

Social Security #: _____ Driver's License: _____ Email: _____

Occupation: _____ Employer: _____

Dental Insurance: _____ Group #: _____

Referred By: _____ Purpose of Initial Visit: _____

Family Dentist: _____ City: _____ How Long: _____ Last Cleaning_____

Family Physician: _____ City: _____ How Long: _____

Physician's Phone #: (____)____-_____ Physician's Fax #: (____)____-_____ Last Physical Exam: _____

Spouse's Name (Parent or Guardian if minor): _____ Date of Birth: _____

Occupation: _____ Employer: _____ Bus. Phone: (____)____-_____ x____

Social Security #: _____ Dental Insurance: _____ Group #: _____

Oral History

(Please Check Y = Yes; N = No)

Present Dental Complaint? _____

Do you have an unpleasant taste or odor in your mouth? ☐Y ☐N Are your teeth sensitive? …….. ☐Y ☐N

Do your gums bleed? If so, when? …… ☐Y ☐N Are your gums sore or swollen? .. ☐Y ☐N

Are you unhappy with the appearance of your teeth? …… ☐Y ☐N Does your jaw click or pop? …… ☐Y ☐N

Do you clench or grind your teeth? …… ☐Y ☐N

Have your ever had orthodontic treatment (braces) …… ☐Y ☐N

Have you had periodontal treatment previously? By whom? _____ ☐Y ☐N

Health History

Height _____ Weight _____ How is your general health? ☐ GOOD ☐ FAIR ☐ POOR

Are you now being treated or have you been treated within the last year by a physician? …….. ☐Y ☐N

Have you ever had any surgery? ……☐Y ☐N Do you have any artificial joints? …….. ☐Y ☐N

Are you now taking any medication, drugs, or pills? INCLUDING ASPIRIN, VITAMINS & HERBS …….. ☐Y ☐N

If yes, please list all medications:_____

_____

_____

Have you taken cortisone/steroids in the last year? ☐Y ☐N

HAVE YOU EVER EXPERIENCED A REACTION TO ANY OF THE FOLLOWING?

Aspirin …… ☐Y ☐N Latex ……. ☐Y ☐N Dental Anesthetics (Novocaine) …… ☐Y ☐N

Penicillin ……. ☐Y ☐N Iodine …… ☐Y ☐N Antibiotics (which ones)_____ ☐Y ☐N

Codeine …… ☐Y ☐N Sleeping Pills . ☐Y ☐N Other Drugs_____ ☐Y ☐N

HAVE YOU EVER HAD:

Heart trouble …… ☐Y ☐N Hepatitis (liver disease) …….. ☐Y ☐N

Heart murmur or Mitral Valve Prolapse ……. ☐Y ☐N Diabetes (sugar in blood) …….. ☐Y ☐N

Stroke …… ☐Y ☐N Anemia or any abnormal blood counts …… ☐Y ☐N

High blood pressure …… ☐Y ☐N Thyroid or parathyroid trouble …….. ☐Y ☐N

Rheumatic fever…… ☐Y ☐N Convulsions …… ☐Y ☐N

Tumor or growth …….. ☐Y ☐N Tuberculosis…… ☐Y ☐N

Radiation, Chemo, Cancer treatment …… ☐Y ☐N Asthma…….. ☐Y ☐N

Arthritis, Rheumatism …… ☐Y ☐N Kidney Disease ……..…… ☐Y ☐N

Jaundice (yellow skin & eyes) …… ☐Y ☐N Lung Disease …….. ☐Y ☐N

Epilepsy or Seizure disorders ……... ☐Y ☐N Ulcers or Stomach problems …….. ☐Y ☐N

Bleeding problems/Blood Disorders …….. ☐Y ☐N Intestinal Disorder …… ☐Y ☐N

Do you consider yourself a nervous person? ……. ☐Y ☐N Do you get up often at night to urinate? How often? _____ ☐Y ☐N

Do you drink alcohol? How much? …….. ☐Y ☐N Are you thirsty much of the time? ……..…… ☐Y ☐N

Do you smoke? How Much? …….. ☐Y ☐N Has anyone in your family had diabetes? Who? _____. ☐Y ☐N

Do you use chewing tobacco? …… ☐Y ☐N Have you tested HIV positive? …… ☐Y ☐N

Do you have AIDS or PREAIDS? …… ☐Y ☐N

Women only: Are you currently pregnant ? …….. ☐Y ☐N If yes, what month? __ Do you use birth control medication? ☐Y ☐N

Have you taken any prescription drugs fenfluramine, fenfluramine combined with phentermine (fen-phen), dexfenfluramine (redux), or other weight loss products? …… ☐Y ☐N

Have you ever taken Bisphosphonates for osteoporosis, chemo therapy, multiple myeloma or other cancers (Fosomax, Actonel, Boniva, Aredia or Zometa)? …… ☐Y ☐N Would you like to speak to the doctor privately about any problem? …… ☐Y ☐N

TO BE SIGNED AND DATED IN DENTAL OFFICE

DATE_____ PATIENT/LEGAL GUARDIAN SIGNATURE_____

Release

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.
I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I hereby authorize payment of insurance benefits directly to the dentist or dental group otherwise payable to me. I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services. I understand that I am financially responsible for payment in full of all accounts.
I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist .
I attest to the accuracy of the information on this form.

We now find it necessary to impose a 1.5% monthly service charge on all outstanding balances.

TO BE SIGNED AND DATED IN DENTAL OFFICE

DATE_____ PATIENT/LEGAL GUARDIAN SIGNATURE_____

DATE_____ DOCTOR'S SIGNATURE_____

(For Office Use Only)

Clinical Information

Vital signs: B.P. _____/_____ Pulse: _____ / minute

	Normal	Abnormal		Normal	Abnormal
Lymph Nodes	_____	_____	Lips	_____	_____
Buccal Mucosa	_____	_____	Floor of Mouth	_____	_____
Tongue	_____	_____	Palate	_____	_____
Alveolar Ridges	_____	_____	Freni	_____	_____

EXAMINATION: _____

Diagnosis **Case Type I II III IV** _____

Gingivitis _____ _____

Periodontitis _____ _____

Periapical Periodontitis _____ _____

Other _____

Occlusion:

Centric _____ **Slide** _____

R. Working _____ **L. Non-Working** _____

L. Working _____ **R. Non-Working** _____

Protrusive _____ **TMJ** _____ **Opening** _____

Angle Class: I II III **Overbite** _____ **Overjet** _____

Alignment _____ **Abrasion** _____

Habits: Clenching Bruxism Tongue Thrust Mouth Breathing **Fremitus** _____

ASA Type: 1 2 3 4

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____