PERIODONTAL PATIENT INFORMATION QUESTIONNAIRE

Name_____ Age _____ Date Of Birth _____Cell Ph # _____
Home
Address _____City _____ Zip_____ Home Ph #_____

Marital Status: S M W D # Of Children_____Drivers Lic. #_____Email_____

Occupation _____ Employer_____ Social Security # _____

Business Address _____ Business Phone_____

Dental Insurance _____ Group # _____

Spouse's Name (Parent Or Guardian If A Minor) _____ Occupation_____

Social Security # _____ Date Of Birth _____

Employer _____ Business Address_____ Business Ph#_____

Spouse's Dental Insurance _____ Group #_____

Referred By _____ Current Dentist_____ How Long?_____

Family Physician _____ City_____ Date Of Last Physical Exam _____

Physician's Phone # _____ Name Of Nearest Relative (Not Living With You) _____ Phone_____

ORAL HISTORY

		YES	NO
1.	Present dental complaint? _____		
2.	Do your gums bleed? If so when? _____	❒	❒
3.	Have you ever had a gum boil? _____	❒	❒
4.	Are your gums sore or swollen?_____	❒	❒
5.	Do you have an unpleasant taste or odor in your mouth? _____	❒	❒
6.	Are you missing any teeth? YES / NO Reason: Cavities ❒ Gum Disease ❒ Were teeth replaced?_____	❒	❒
7.	When were teeth last cleaned? _____ How long before that? _____		
8.	How often do you brush your teeth? _____ When?_____		
	Hand toothbrush ( ) Electric ( ) Is it: Soft ( ) Medium ( ) Hard ( )		
9.	Are your teeth sensitive? _____	❒	❒
10.	Have you ever had orthodontic treatment (braces)? _____	❒	❒
11.	Have you had periodontal treatment previously? YES / NO By whom?_____		

HEALTH HISTORY

1. Height_____ Weight _____ How is your general health? _____Good / Fair / Poor
2. Are you now being treated or have you been treated within the last year by a physician? _____ ❒ ❒
3. If yes, please indicate for what_____
4. Have you ever had any surgery? _____ ❒ ❒
5. Are you now taking any medication, drugs, or pills? _____ ❒ ❒
   If yes, please list those drugs_____
6. Have you taken cortisone or steroids within the last year? _____ ❒ ❒
7. Have you ever experienced an allergic or adverse reaction to any of the following?
   Aspirin: YES / NO Sleeping pills: YES / NO LATEX ALLERGY: YES / NO
   Codeine: YES / NO Penicillin: YES / NO Dental anesthetics (Novocaine): YES / NO
   Other drugs, antibiotics or medications? If yes, please list: _____
8. Are you taking or have you ever taken Biophosphonates for Osteoporosis, Multiple Myeloma or other cancers? ❒ ❒
   (Such as: Reclast, Fosomax, Actonel, Boniva, Aredia or Zometa)

Have you ever had?:	YES	NO		YES	NO		YES	NO
Heart trouble	❒	❒	Stroke	❒	❒	Hepatitis (liver disease)	❒	❒
Heart murmur	❒	❒	Rheumatic Fever	❒	❒	Venereal Disease	❒	❒
High blood pressure	❒	❒	Arthritis	❒	❒	Diabetes	❒	❒
Epilepsy	❒	❒	Convulsions	❒	❒	If so, what is your HB/A1C_____		
Bleeding Problems	❒	❒	Tuberculosis	❒	❒	Radiation or X-ray Treatment	❒	❒
Asthma	❒	❒	Kidney Disease	❒	❒	Jaundice	❒	❒
Lung Disease	❒	❒	Gastrointestinal Disorder	❒	❒	Ulcers	❒	❒
Joint Replacement	❒	❒	HIV Positive/ AIDS	❒	❒			

9. Do you get up often at night to urinate? _____ ❒ ❒
10. Do you take Pre-medication? _____ ❒ ❒
11. Are you thirsty much of the time?_____ ❒ ❒
12. Has anyone in your family had diabetes? _____ ❒ ❒
13. Do you consider yourself a nervous person?_____ ❒ ❒
14. Do you smoke? _____ ❒ ❒
15. **FEMALES** Are you taking birth control pills? YES / NO Are you pregnant at the present time? YES / NO If Yes, what month?_____

Date _____ **Signature**_____ **Dr.'s Initials**_____

CONSENT TO PERIODONTAL TREATMENT

Treatment Fees. Payment is due in full at the time treatment is rendered. All financial arrangements must be made prior to treatment. Insurances will be submitted as a courtesy. The insured is responsible to know what their insurance benefits are and how much has been utilized for any given year.

Alternative treatments. In making the below recommendations, Doctor has advised me that alternative treatments exist, which may include, but are not necessarily limited to: frequent scaling and root planing, surgical curettage, cleaning, oral hygiene instructions and evaluations, tooth extractions, dentures, implant treatments, consistent maintenance therapy.

Non-treatment risks. Doctor has advised me that no treatment may result in a health risk. If this periodontal condition persists, and is not corrected, the risks may include, but are not necessarily limited to: premature tooth loss and the need for dentures, gum recession, bad breath, inability to perform adequate oral hygiene, loosening of teeth, abscesses or infections, pain, poor chewing; tooth sensitivity, tooth movements and worsening of periodontal disease.

Treatment risks. I also understand that inherent to any procedure, and because of an individual's variations, certain potential risks are involved with this treatment. These may include: temporary swelling, bleeding, intermittent pain, nausea, hot or cold tooth sensitivity, gum recession, exposure of crown margins, temporary speaking difficulties, infections, tooth mobility, food impaction, root canal therapy, joint pain/disorder.

I have received an opportunity to ask any questions about the proposed treatment and all questions that I have asked have been answered to my complete satisfaction before this consent was signed.

I also understand that the proposed treatment contains no guarantee, or warranty of success. Each individual case is unpredictable, making it impossible to surmise results. Therapeutic results are always dependent on individual compliance. I understand that for successful periodontal results and to lessen the dangers of complications, the following treatment conditions are required of me: excellent oral hygiene; consistent maintenance appointments; proper diet, strict adherence to instructions, and the wearing of any appliances.

I certify that I have read and understand this authorization for proposed treatment, medication or surgery described above. I accept the risks in hopes of obtaining the desired beneficial result.

PROPOSED TREATMENT PLAN				
Date	Treatment	Cost	Signature	Todays Date