PRECISION
Periodontics and Implant Dentistry

NEW PATIENT INFORMATION

PATIENT PERSONAL INFORMATION

Title: _____ **Preferred Name:** _____ **Birth Date:** _____ **Sex:** _____ **Age:** _____

Name (Last, First, M): _____ **Marital Status:** _____

Address: _____ **Apt/Unit:** _____

City: _____ **State:** _____ **Zip:** _____ **Driver's License** (Number, State): _____

Cell: _____ **Work:** _____ **Home:** _____

Email: _____ **Confirm By:** O Cell O Work O Home O Email

SSN: _____ **Health Care Guardian:** _____ **Phone:** _____

Occupation: _____ **Employer/School:** _____

Spouse Name: _____ **Occupation:** _____

How did you find us? _____ **Preferred Language:** _____

Referred by: _____ **Phone:** _____

General Dentist: _____ **Phone:** _____

PERSON RESPONSIBLE/GUARANTOR FOR PAYING BILLS

Title: _____ **Preferred Name:** _____ **Birth Date:** _____ **Sex:** _____ **Age:** _____

Name (Last, First, M): _____ **Marital Status:** _____

Address: _____ **Apt/Unit:** _____

City: _____ **State:** _____ **Zip:** _____ **Driver's License** (Number, State): _____

Cell: _____ **Work:** _____ **Home:** _____

Email: _____ **SSN:** _____

DO YOU HAVE PRIMARY DENTAL INSURANCE?

Insurance Name: _____

Group Number/Name: _____

Subscriber ID: _____ **Phone:** _____

Employer Name: _____

Subscriber (Last, First): _____ **Birth Date:** _____

Subscriber Address: _____ **Apt/Unit:** _____

City: _____ **State:** _____ **Zip:** _____

Relationship to Patient: _____

DO YOU HAVE SECONDARY DENTAL INSURANCE?

Insurance Name: _____

Group Number/Name: _____

Subscriber ID: _____ **Phone:** _____

Employer Name: _____

Subscriber (Last, First): _____ **Birth Date:** _____

Subscriber Address: _____ **Apt/Unit:** _____

City: _____ **State:** _____ **Zip:** _____

Relationship to Patient: _____

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PATIENT MEDICAL INFORMATION

Last Physical (date): _____**Weight:** _____ **Height:**_____**Are you under the care of a physician?** ☐ Y ☐ N

Allergic To

☐ Y ☐ N No Known Allergies	☐ Y ☐ N Augmentin	☐ Y ☐ N Amoxicillin
☐ Y ☐ N Artificial Valves	☐ Y ☐ N Aspirin	☐ Y ☐ N Bactrim
☐ Y ☐ N Barbiturates / Sleeping Pills	☐ Y ☐ N Codeine	☐ Y ☐ N Erythromycin
☐ Y ☐ N Ibuprofen	☐ Y ☐ N Iodine	☐ Y ☐ N Latex Rubber
☐ Y ☐ N Levaquin	☐ Y ☐ N Local Anesthetics (Novocain)	☐ Y ☐ N Metals
☐ Y ☐ N Epinephrine	☐ Y ☐ N Penicillin	☐ Y ☐ N Prior Hepatitis
☐ Y ☐ N Sulfa Drugs	☐ Y ☐ N Tetracycline	☐ Y ☐ N Zithromax

☐ Y ☐ N Other Medications or Sensitivities _____

Check, if applicable

☐ Y ☐ N Any changes since last visit?	☐ Y ☐ N Any medical concerns?	☐ Y ☐ N Abnormal Bleeding
☐ Y ☐ N AIDS/HIV/ARC Infection	☐ Y ☐ N Alcohol/Drug Abuse	☐ Y ☐ N Angina
☐ Y ☐ N Anemia	☐ Y ☐ N Ankles Swell	☐ Y ☐ N Anorexia
☐ Y ☐ N Anxiety	☐ Y ☐ N Arteriosclerosis	☐ Y ☐ N Artificial Bones/Joints
☐ Y ☐ N Arthritis	☐ Y ☐ N Asthma	☐ Y ☐ N Autoimmune Disease
☐ Y ☐ N Back Problems	☐ Y ☐ N Bladder Trouble	☐ Y ☐ N Blood Clotting Problem
☐ Y ☐ N Blood Disorders	☐ Y ☐ N Blood Transfusion	☐ Y ☐ N Bulimia
☐ Y ☐ N Bronchitis	☐ Y ☐ N Cancer/Tumor or Growth	☐ Y ☐ N Cardiac Pacemaker
☐ Y ☐ N Chemotherapy	☐ Y ☐ N Chest Pain Upon Exertion	☐ Y ☐ N Cholesterol
☐ Y ☐ N Color Blindness	☐ Y ☐ N Congenital Heart Defect	☐ Y ☐ N Contact Lenses
☐ Y ☐ N Congestive Heart Failure	☐ Y ☐ N COPD	☐ Y ☐ N Cosmetic Surgery
☐ Y ☐ N Damaged Heart Valve	☐ Y ☐ N Diabetes/Hypoglycemia	☐ Y ☐ N Emphysema
☐ Y ☐ N Environmental Allergies	☐ Y ☐ N Epilepsy	☐ Y ☐ N Fainting Spells
☐ Y ☐ N Fever Blister	☐ Y ☐ N Frequent Headaches	☐ Y ☐ N Frequent Neck Pain
☐ Y ☐ N Frequently Dry Mouth/Sjogren	☐ Y ☐ N Gag Reflex	☐ Y ☐ N Gall Bladder Trouble
☐ Y ☐ N GERD	☐ Y ☐ N Glaucoma/Cataracts	☐ Y ☐ N Hay Fever
☐ Y ☐ N Heart Attack	☐ Y ☐ N Heart Disease/Condition	☐ Y ☐ N Heart Murmur
☐ Y ☐ N Heart Surgery	☐ Y ☐ N Hepatitis	☐ Y ☐ N Herpes
☐ Y ☐ N High Blood Pressure	☐ Y ☐ N Hives	☐ Y ☐ N Jaundice
☐ Y ☐ N Jaw Problems TMJ/TMD	☐ Y ☐ N Joint Replacement	☐ Y ☐ N Kidney Problems
☐ Y ☐ N Leukemia	☐ Y ☐ N Liver Disorder	☐ Y ☐ N Low Blood Pressure
☐ Y ☐ N Lupus	☐ Y ☐ N Mental Health Problems	☐ Y ☐ N Mitral Valve Prolapse
☐ Y ☐ N Myasthenia Graves	☐ Y ☐ N Pacemaker	☐ Y ☐ N Prostate Problems
☐ Y ☐ N Psychiatric Disorders	☐ Y ☐ N Premedicate	☐ Y ☐ N respiratory Disorder
☐ Y ☐ N Prosthetic Replacement	☐ Y ☐ N Radiation Treatment	☐ Y ☐ N Rheumatoid Arthritis
☐ Y ☐ N Rheumatic Fever	☐ Y ☐ N Rheumatic Heart Disease	☐ Y ☐ N Sexually Transmitted Disease
☐ Y ☐ N Scarlet Fever	☐ Y ☐ N Seizures	☐ Y ☐ N Skin Rash
☐ Y ☐ N Shingles	☐ Y ☐ N Shortness of Breath	☐ Y ☐ N Stroke
☐ Y ☐ N Sinus Trouble	☐ Y ☐ N Stomach Problems and Ulcers	☐ Y ☐ N Tattoos
☐ Y ☐ N Substance Abuse	☐ Y ☐ N Thyroid Condition	☐ Y ☐ N Urinate Frequently
☐ Y ☐ N Tuberculosis	☐ Y ☐ N Unusual Weight Loss	☐ Y ☐ N Premedicate
☐ Y ☐ N Venereal Disease	☐ Y ☐ N Xray or Cobalt Treatment	

DENTAL QUESTIONNAIRE

Dental History

Reason for today's visit?_____

Are you in pain now? ☐ Y ☐ N **How long** (months/years)**?** _____ **Level (1-10)?**_____

Date of last dental exam? _____ **Date of last dental x-rays?** _____

Have you had any previous dental experiences worth noting? ☐ Y ☐ N **Details:** _____

_____

_____

Have you had any injuries to your teeth, face or jaw? ☐ Y ☐ N **Details:** _____

_____

_____

How many times a day do you brush?_____ **floss?**_____ **What type of bristles do you use** (hard, medium, soft)**?** _____

Previous Dentist: _____**Phone:** _____

Are you happy with your smile? ☐ Y ☐ N **Details:**_____

_____

_____

Please indicate if you have any of the following issues.

- ☐ Bad Breath
- ☐ Blisters/sores in or around mouth
- ☐ Burning Sensation
- ☐ Difficulty Chewing
- ☐ Discomfort, Clicking or Popping in Jaw
- ☐ Erythromycin
- ☐ Lost/Broken Fillings
- ☐ Red, Swollen or Bleeding Gums
- ☐ Sensitive Tooth, Teeth or Gums
- ☐ Stained Teeth
- ☐ Tartar Buildup
- ☐ Yellowing Teeth
- ☐ Barbiturates / Sleeping Pills
- ☐ Broken/chipped Tooth
- ☐ Codeine
- ☐ Difficulty Swallowing
- ☐ Dry Mouth
- ☐ Locking Jaw
- ☐ Recession
- ☐ Ringing in Ears
- ☐ Sore Jaw
- ☐ Swelling Inside Mouth
- ☐ Teeth Grinding

Are you concerned about the appearance of your teeth or face. If yes, check all that apply.

- ☐ Appearance of Gums
- ☐ Facial Profile
- ☐ Yellowing/Graying Teeth
- ☐ Crowded/Crooked Teeth
- ☐ Spacing Between Teeth

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MEDICAL QUESTIONNAIRE

Medical Questionnaire

Name of Preferred Pharmacy? _____ **Phone:** _____

Pharmacy Address: _____ **Suite/Unit:** _____

City: _____ **State:** _____ **Zip:** _____

Please list any known drug reactions, drug allergies or sensitivities: _____

_____

Have you had serious illnesses, operations or been hospitalized within the last 5 years? ☐ Y ☐ N **Details:** _____

_____

_____

Are you currently taking any medications? ☐ Y ☐ N **If Yes, please provide details:**

Name: _____	**Dosage:** _____	**Times per day:** _____
Name: _____	**Dosage:** _____	**Times per day:** _____
Name: _____	**Dosage:** _____	**Times per day:** _____
Name: _____	**Dosage:** _____	**Times per day:** _____
Name: _____	**Dosage:** _____	**Times per day:** _____
Name: _____	**Dosage:** _____	**Times per day:** _____
Name: _____	**Dosage:** _____	**Times per day:** _____
Name: _____	**Dosage:** _____	**Times per day:** _____
Name: _____	**Dosage:** _____	**Times per day:** _____
Name: _____	**Dosage:** _____	**Times per day:** _____
Name: _____	**Dosage:** _____	**Times per day:** _____
Name: _____	**Dosage:** _____	**Times per day:** _____

Do you require premedication for dental procedures? ☐ Y ☐ N **Details:** _____

_____

Have you taken bisphosphonates (Fosamax, Boniva, Zometa, Actonel, Didronel, Aredia, Skelid, Reclast)? ☐ Y ☐ N

Have you ever taken Phenten/Redux? ☐ Y ☐ N

Do you use alcoholic beverages? ☐ Y ☐ N

Do you use tobacco products? ☐ Y ☐ N **If Yes, What type, how much, and for how long?** _____

Do you wear contact lenses? ☐ Y ☐ N

Women Only

Are you pregnant? ☐ Y ☐ N **If Yes, What is you due date?** _____ **Are you currently nursing?** ☐ Y ☐ N

Are you on hormone replacement therapy? ☐ Y ☐ N **Are you on birth control/fertility drugs?** ☐ Y ☐ N

Additional Comments

Any Disease, Condition or Problem Not Listed? ☐ Y ☐ N **Please list** _____

_____

_____

_____

_____	_____	_____
Print Patient Name (Guardian if Minor)	**Signature**	**Date**