

# Periodontal Associates, P.A.

Practice Limited to Periodontics and Implants

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## Health Questionnaire

Name \_\_\_\_\_ Date \_\_\_\_\_ Sex M / F  
Street/P.O. Box \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Pharmacy name \_\_\_\_\_ Pharmacy location \_\_\_\_\_  
Home # \_\_\_\_\_ Cell # \_\_\_\_\_ Work # \_\_\_\_\_  
Email \_\_\_\_\_ Use (circle one) Home/Work/Cell/Email for appointment reminders  
Reason for today's appointment? \_\_\_\_\_  
In an emergency, whom should we contact? \_\_\_\_\_ Phone \_\_\_\_\_

## Medical History

Primary Physician \_\_\_\_\_ Phone \_\_\_\_\_  
Last physical exam \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_  
Are you under the care of a physician specialist? (i.e. cardiologist, etc.) Yes / No Who? \_\_\_\_\_  
Do you take aspirin daily? Yes / No Dose \_\_\_\_\_ Was this physician prescribed? Yes / No Who? \_\_\_\_\_  
Do you have an artificial joint? Yes / No Surgeon \_\_\_\_\_ When \_\_\_\_\_ What joint \_\_\_\_\_  
Do you smoke or chew tobacco products? Yes / No How much? \_\_\_\_\_ How long \_\_\_\_\_  
Do you smoke or use marijuana? Yes / No How often? \_\_\_\_\_ How long \_\_\_\_\_  
Do you drink alcohol? Yes / No How much? \_\_\_\_\_ How often? \_\_\_\_\_  
Do you consider yourself to be in good health? Yes / No

## Allergies –Do you have an allergy or adverse reaction to: (please circle yes or no to each, use extra space to elaborate)

Penicillin	Yes / No	Latex	Yes / No
Codeine / Oxycodone	Yes / No	Aspirin	Yes / No
Motrin / Ibuprofen	Yes / No	Food	Yes / No _____
Local Anesthesia	Yes / No	Antibiotics or Other Medications	Yes / No _____
Novocaine / Lidocaine	Yes / No	Other	Yes / No _____

## Do you have or have you had any of the following? (please circle yes or no to each, use extra space to elaborate)

AIDS / HIV	Yes / No	COPD	Yes / No	Pacemaker	Yes / No
Allergies	Yes / No	Diabetes	Yes / No	Prosthetic Heart Valve	Yes / No
Angina	Yes / No	Fainting Spells	Yes / No	Radiation Treatment	Yes / No
Artificial Joint(s)	Yes / No	Glaucoma	Yes / No	Respiratory Disease	Yes / No
Arthritis	Yes / No	Heart Attack	Yes / No	Rheumatoid Arthritis	Yes / No
Asthma	Yes / No	Heart Disease	Yes / No	Rheumatic Heart Disease	Yes / No
Autoimmune Disease	Yes / No	Recent Heart Stent	Yes / No	Rheumatic Fever	Yes / No
Bacterial Endocarditis	Yes / No	Heart Transplant	Yes / No	Seizures	Yes / No
Bleeding Problems	Yes / No	Hepatitis (Type: _____)	Yes / No	Sexually Transmitted Disease	Yes / No
Blood Disease	Yes / No	High Blood Pressure	Yes / No	Sinus Problems	Yes / No
Bruise Easily	Yes / No	Hives/Skin Rash	Yes / No	Stomach/Intestinal Ulcers	Yes / No
Cancer	Yes / No	Kidney Disease	Yes / No	Stroke	Yes / No
Circulatory Problems	Yes / No	Liver Disease	Yes / No	Thyroid Disease	Yes / No
Congenital Heart Defect	Yes / No	Low Blood Pressure	Yes / No	Tuberculosis	Yes / No
Congestive Heart Failure	Yes / No	Osteoporosis/Osteopenia	Yes / No	Weight Changes	Yes / No

Anticoagulants/ blood thinners (i.e.: Coumadin, Eliquis, Xarelto, Pradaxa, etc.) \_\_\_\_\_

Bisphosphonate use (i.e.: Fosamax, Prolia, Zometa, etc.) \_\_\_\_\_

Mental Health (i.e.: depression etc.) \_\_\_\_\_

**Women:** Are you pregnant? Yes / No OB \_\_\_\_\_ Phone \_\_\_\_\_ Due Date \_\_\_\_\_

Taking birth control pills? Yes / No

**List all prescribed medications with dosages – indicate the prescriber if not primary physician** (antibiotics, anticoagulants, steroids, statins, insulin, tranquilizers, blood pressure medication, etc. ) Use separate sheet, if preferred or needed.

**List all over-the-counter medications/herbal supplements with dosages** (vitamins, minerals, St. John’s Wort, aspirin) Use separate sheet, if preferred or needed.

**Have you had any hospitalizations, conditions, diseases, or problems not listed on the front?** Yes / No (please list/describe) Use separate sheet, if preferred or needed.

**Have you had any health changes in the past year?** Yes / No (please describe) Use Separate sheet if preferred or needed.

**Dental History**

Dentist \_\_\_\_\_ Phone \_\_\_\_\_ Date of last dental visit \_\_\_\_\_

Do you take antibiotics prior to a dental appointment? Yes / No Who prescribed? \_\_\_\_\_

Why? \_\_\_\_\_

When was your last dental cleaning \_\_\_\_\_ Frequency \_\_\_\_\_

How often do you brush \_\_\_\_\_ Floss \_\_\_\_\_ Other \_\_\_\_\_

Are you having any discomfort/pain Yes / No Do you have pain in jaw or in front of ear Yes / No

Are your teeth sensitive to hot/cold Yes / No Do you have a bad taste or odor Yes / No

Are your teeth sensitive to biting/chewing Yes / No Do you breathe through your mouth Yes / No

Do your gums bleed Yes / No Are you nervous about dental treatment Yes / No

Do you clench/grind teeth Yes / No Are you under significant stress Yes / No

Does your jaw “click” Yes / No Are you happy with appearance of teeth Yes / No

Have you had orthodontic treatment (braces) Yes / No When/Where \_\_\_\_\_

Have you had previous periodontal treatment Yes / No When/Where \_\_\_\_\_

**Personal**

How did you hear about our office \_\_\_\_\_

Marital status \_\_\_\_\_

Number and ages of children \_\_\_\_\_

Occupation \_\_\_\_\_

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

# *Insurance Information*

## *Primary Dental Insurance*

Subscriber Name \_\_\_\_\_

Subscriber Date of Birth \_\_\_\_\_

Insurance Name \_\_\_\_\_

Claims Address \_\_\_\_\_

Insurance Phone \_\_\_\_\_

Group Name or Employer \_\_\_\_\_

Group Number \_\_\_\_\_

Subscriber ID Number \_\_\_\_\_

## *Secondary Dental Insurance*

Subscriber Name \_\_\_\_\_

Subscriber Date of Birth \_\_\_\_\_

Insurance Name \_\_\_\_\_

Claims Address \_\_\_\_\_

Insurance Phone \_\_\_\_\_

Group Name or Employer \_\_\_\_\_

Group Number \_\_\_\_\_

Subscriber ID Number \_\_\_\_\_

## *Please Read and Sign*

*I have completed this form correctly to the best of my knowledge and certify that I am the patient or duly authorized general agent of the patient to furnish information requested. I understand that even though I may have insurance coverage, I am responsible for payment of services.*

Signature \_\_\_\_\_ Date \_\_\_\_\_

## *Financially Responsible Party*

Name \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_