

Date \_\_\_\_\_ (PLEASE PRINT) Home Phone (\_\_\_\_) \_\_\_\_\_

Patient \_\_\_\_\_ (\_\_\_\_)  
Last Name First Name Middle Initial Preferred Name

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

E-Mail \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_

Sex  M  F Age \_\_\_\_\_ Birthdate \_\_\_\_\_  Married  Single  Other

**Emergency Contact:** Name \_\_\_\_\_ Phone Number (\_\_\_\_) \_\_\_\_\_

Do we have permission to:  Leave Messages?  Remind you of premed?  Discuss your dental care with household members?

**MEDICAL HISTORY**

Physician's Name \_\_\_\_\_ Physician's phone (\_\_\_\_) \_\_\_\_\_

Physician's Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Do you smoke?  Yes  No If so, how long?\_\_\_\_ Are you able to sit in a dental chair for a long period of time?  Yes  No

**DENTAL HISTORY**

Dentist Name \_\_\_\_\_ Dentist phone(\_\_\_\_) \_\_\_\_\_

Have you had any complications with previous dental treatment?  Yes  No

You were referred to us for: \_\_\_\_\_

Have you had any of the following dental treatment?  Periodontal (Root Planing,Surgery)  Restorative (Fillings,Crown,Bridge)  
 Endodontic (Root Canals)  Orthodontic (Braces)  TMD/TMJ (Jaw Joint)

Are you experiencing any dental pain/where? \_\_\_\_\_ Describe:  Sharp  Dull  Continuous  Intermittent

Is pain triggered by:  Hot  Cold  Chewing  Sweets  Spontaneous  Wakes me from sleep

Does anything lessen the pain?(Explain) \_\_\_\_\_

**GINGIVAL HEALTH & ORAL HYGIENE**

I use a:  Hard or medium bristle brush  Soft bristle brush  Battery- powered  Sonicare/Oral B  Other

I brush for \_\_\_\_\_ minutes \_\_\_\_\_ times a day. I floss \_\_\_\_\_ times a week. I rinse with \_\_\_\_\_

Any other oral hygiene aids? \_\_\_\_\_

**PARAFUNCTIONAL HABITS & TMD/TMJ**

Do you clench or grind your teeth?  Yes  No Have you ever worn a mouth/bite guard?  Yes  No

Do your jaw joints:  pop  click  cause you pain Any difficulty opening or closing?  Yes  No

**IMPROVING ESTHETICS & FUNCTION**

My teeth are sensitive to: \_\_\_\_\_ My dentures are uncomfortable or ill-fitting  Yes  No

I would like to replace missing teeth  Yes  No I would like to learn about dental implants  Yes  No

\*I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold Southern Oregon Periodontics and its staff, responsible for any action they take or do not take because of errors or omissions that I have made in the completion of this form.

Patient/Guardian Signature

Date

Please list any medications that you are currently taking including premedication for dental appointments:

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- Allergies:( Check all that apply)
- |                                     |                                   |                                       |                                    |                                 |
|-------------------------------------|-----------------------------------|---------------------------------------|------------------------------------|---------------------------------|
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Codeine  | <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Iodine    | <input type="checkbox"/> Dental |
| <input type="checkbox"/> Latex      | <input type="checkbox"/> Aspirin  | <input type="checkbox"/> Sulfa        | <input type="checkbox"/> Cortisone | Anesthetic                      |
| <input type="checkbox"/> Metals     | <input type="checkbox"/> Benadryl | <input type="checkbox"/> Tetracycline | <input type="checkbox"/> Seasonal  |                                 |

Other: \_\_\_\_\_

Have you had or do you currently have any of the following? If yes, please check the box.

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Abnormal Bleeding       | <input type="checkbox"/> Fainting Spells                  | <input type="checkbox"/> Osteoporosis                    |
| <input type="checkbox"/> Alcoholism              | <input type="checkbox"/> Fever Blisters                   | <input type="checkbox"/> Pace Maker                      |
| <input type="checkbox"/> Anemia                  | <input type="checkbox"/> Frequent Headaches               | <input type="checkbox"/> Pneumocystitis                  |
| <input type="checkbox"/> Angina Pectoris         | <input type="checkbox"/> Glaucoma                         | <input type="checkbox"/> Pregnant                        |
| <input type="checkbox"/> Arthritis               | <input type="checkbox"/> Heart Attack                     | <input type="checkbox"/> Prosthetic Joints               |
| <input type="checkbox"/> Artificial Heart Valve  | <input type="checkbox"/> Heart Condition                  | <input type="checkbox"/> Psychiatric Problems            |
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Heart Murmur                     | <input type="checkbox"/> Radiation Therapy               |
| <input type="checkbox"/> Birth Control           | <input type="checkbox"/> Heart Surgery                    | <input type="checkbox"/> Rheumatic Fever                 |
| <input type="checkbox"/> Bisphosphonates         | <input type="checkbox"/> Hemophilia                       | <input type="checkbox"/> Rheumatoid Arthritis            |
| <input type="checkbox"/> Bronchitis              | <input type="checkbox"/> Hepatitis A                      | <input type="checkbox"/> Seasonal Allergies or Hay fever |
| <input type="checkbox"/> Cancer-Chemotherapy     | <input type="checkbox"/> Hepatitis B                      | <input type="checkbox"/> Seizures                        |
| <input type="checkbox"/> Colitis                 | <input type="checkbox"/> High Blood Pressure              | <input type="checkbox"/> Sexually Transmitted Disease    |
| <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> HIV or AIDS                      | <input type="checkbox"/> Shingles                        |
| <input type="checkbox"/> Cortisone               | <input type="checkbox"/> Kidney Problems                  | <input type="checkbox"/> Sickle Cell Disease             |
| <input type="checkbox"/> Cosmetic Surgery        | <input type="checkbox"/> Liver Disease                    | <input type="checkbox"/> Sinus Problems                  |
| <input type="checkbox"/> Coumadin/Warfarin       | <input type="checkbox"/> Low Blood Pressure               | <input type="checkbox"/> Smoke or Use Tobacco            |
| <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Lupus                            | <input type="checkbox"/> Stroke                          |
| <input type="checkbox"/> Difficulty Breathing    | <input type="checkbox"/> Migraines                        | <input type="checkbox"/> Thyroid Problems                |
| <input type="checkbox"/> Dry Mouth               | <input type="checkbox"/> Mitral Valve Prolapse            | <input type="checkbox"/> Transfusion                     |
| <input type="checkbox"/> Emphysema               | <input type="checkbox"/> Mouth Sores or Ulcers            | <input type="checkbox"/> Tuberculosis                    |
| <input type="checkbox"/> Endocarditis            | <input type="checkbox"/> Nonprescribed Drug Use/Addiction | <input type="checkbox"/> Ulcers                          |
| <input type="checkbox"/> Epilepsy                | <input type="checkbox"/> Nursing                          | <input type="checkbox"/> Yellow Jaundice                 |

Please provide any additional information related to your conditions and/or describe any conditions not listed above:

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\_\_\_\_\_  
 Patient/Guardian Signature

\_\_\_\_\_  
 Date