WESTERN RESERVE PERIODONTICS
Periodontics and Implant Surgeries

MINOR PATIENT INFORMATION FORM

(The following information is strictly confidential.)

Date _____

Patient Name _____ Age _____

Why are you now seeking periodontal treatment? _____

Birth Date _____ Male _____ Female _____ Home Phone ( ) _____

Address _____ City _____ ZIP _____

Name of Dentist _____ How Long? _____ Phone ( ) _____

Name of Physician _____ How long? _____ Phone ( ) _____

Parent or Responsible Party _____ Relationship to Patient _____

Address _____ City _____ ZIP _____

Home Phone ( ) _____ Work Phone ( ) _____

Dental Insurance: ❑Yes ❑No Insured SS No.: _____

Whom may we thank for referring you? _____

In case of emergency please notify _____ Phone ( ) _____

MEDICAL HISTORY

Height _____ Weight _____ How is your general health? _____

Date of last physical _____ Are you under active medical care? _____

If so, for what? _____

Please check the correct response:

(1) Have there been any changes in your general health recently? ..... ❑No ❑Yes
(2) Have you lost or gained an excessive amount of weight recently? ..... ❑No ❑Yes
(3) Have you been seriously ill within the last year? ..... ❑No ❑Yes
(4) Have you had surgery (an operation) within the last year? ..... ❑No ❑Yes
(5) Have you been treated for a growth or tumor? ..... ❑No ❑Yes
(6) Have you ever had excessive bleeding requiring treatment? ..... ❑No ❑Yes
(7) Have you experienced chest pain or shortness of breath going up a flight of stairs? ..... ❑No ❑Yes
(8) Have you noticed an increase in frequency of urination? ..... ❑No ❑Yes
(9) Have you noticed an increase in thirstiness? ..... ❑No ❑Yes
(10) Please check any of the following which you have had: ❑ **NONE OF THE BELOW**

❑Anemia
❑Arthritis
❑Artificial Joint
❑Cancer
❑Chest Pain
❑Heart Attack
❑Heart Disease
❑Heart Surgery
❑Heart Pacemaker
❑Artificial Heart Valve
❑Mitral Valve Prolapse
❑Heart Murmur
❑High Blood Pressure
❑Low Blood Pressure
❑Stroke
❑Diabetes
❑Family History of Diabetes
❑Osteoporosis
❑Steroid/Cortisone treatments
❑Epilepsy/Seizures
❑Asthma/Emphysema
❑Rheumatic Fever
❑Tuberculosis
❑Glaucoma
❑Ulcers
❑Kidney Disorder
❑HIV/AIDS
❑Skin Disease
❑Thyroid Disorder
❑Fainting/Dizziness
❑Hepatitis/Jaundice
❑Liver Disease
❑Venereal Disease (Herpes, Gonorrhea, Syphilis)
❑Other _____

OVER ➔

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Please check the correct response:

11) Have you ever or are you presently undergoing psychiatric care? ❑No ❑Yes

12) Have you ever experienced an unusual reaction to dental local anesthesia ("Novocaine")? ❑No ❑Yes

13) Are you allergic to any drugs? ❑No ❑Yes

If yes, please indicate: ❑Penicillin ❑Aspirin ❑Codeine

❑Other_____

14) Are you presently taking any drugs or medications and have you taken any during the last year? ❑No ❑Yes

If yes, please list:_____

15) Are you presently taking any herbal or vitamin preparations? ❑No ❑Yes

If yes, please list _____

16) Do you take aspirin or nonsteroidal anti-inflammatories (like Advil) on a daily basis? ❑No ❑Yes

17) FEMALES: Are you pregnant at this time? ❑No ❑Yes

Do you take birth control pills or have you in the past? ❑No ❑Yes

DENTAL HISTORY

18) How often do you go to the dentist?_____ Date of last visit_____

19) What was done at that time?_____

20) When were your teeth last cleaned?_____

21) Have you had previous periodontal treatment? ❑No ❑Yes

If yes, describe treatment_____ When_____

22) Have you had previous orthodontic treatment? ❑No ❑Yes

23) Have you ever had an injury to the face or jaws? ❑No ❑Yes

24) Are you satisfied with your dental appearance? ❑No ❑Yes

25) Do you feel that your teeth bite together properly? ❑No ❑Yes

26) Do you notice food catching between your teeth frequently? ❑No ❑Yes

27) How often do you brush your teeth?_____ ❑Hard ❑Medium ❑Soft Brush

28) Do you use any other oral hygiene devices or materials? ❑No ❑Yes

If yes, what and how often?_____

29) Do your gums bleed when you brush your teeth? ❑No ❑Yes

30) Are you aware of bad breath? ❑No ❑Yes

31) Do you have discomfort in your mouth now? ❑No ❑Yes

32) Have you had any extensive dental treatment? ❑No ❑Yes

If yes, explain_____

33) What kind of dental health do you think you are in?_____

34) Do you have any of the following habits?

❑Grind teeth ❑Bite lip, cheek, or tongue ❑Clench teeth

❑Smoke or chew tobacco: How much?_____ ❑Other_____

Is there any additional information which will help us to help you?_____

_____

This medical/dental history is accurate to the best of my knowledge.

Signature_____

Relationship to Patient _____