Connecticut Periodontal & Implant Associates

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Welcome To Our Practice!

Date: _____

Patient's Name_____ Title_____ Preferred name_____

Street_____ City_____ State_____ Zip_____

Birth Date_____ Sex_____ Height_____ Weight_____

Marital status_____ Spouse's name _____

Phone: Home_____ Cell_____ Office_____

Email address_____ Preferred method(s) of contact: Home / Cell / Text / Email

Reason for visit_____ Referred by_____

Dentist_____ Address_____ Phone_____

Physician_____ Address_____Phone_____

Last physical exam_____ Preferred pharmacy _____

Employer_____ Occupation_____

Name of Patient's Dental Ins. Carrier_____ Medical Insurance Carrier_____

If covered, Spouse's Dental Ins. Carrier_____ Person responsible for account_____

Emergency Contact Name_____ Phone number_____

PLEASE CHECK ✓ YES, NO, OR DON'T KNOW AND <u>UNDERLINE</u> IF CONDITIONS, SYMPTOMS OR DRUGS ARE STATED.	**YES**	**NO**	**DON'T KNOW**
1. Do you consider yourself to be in good health?	1. _____	_____	_____
2. Are you presently under a physician's care?	2. _____	_____	_____
3. Are you taking any medicine at the present time? *List on next page.*	3. _____	_____	_____
4. Have you ever had an operation?	4. _____	_____	_____
5. Have you been seriously ill?	5. _____	_____	_____
6. Have you ever been hospitalized?	6. _____	_____	_____
7. Have you ever received radiation or chemotherapy treatments?	7. _____	_____	_____
8. Have you ever been told by a physician that you have heart trouble and if so, when? _____	8. _____	_____	_____
9. Have you ever been told by a physician that your blood pressure is **high** or **low**?	9. _____	_____	_____
10. Are your joints often painful or swollen? Do you have arthritis?	10. _____	_____	_____
11. Have you ever been treated for anemia (thin blood)?	11. _____	_____	_____
12. Do you have or has anyone in your family had diabetes? Who? _____	12. _____	_____	_____
13. Have you ever had fainting spells or seizures?	13. _____	_____	_____
14. Have you ever had liver trouble, hepatitis, or jaundice?	14. _____	_____	_____
15. Have you ever been treated for kidney or bladder trouble?	15. _____	_____	_____
16. Are you sensitive to or have you had any unusual reactions to **latex** or any medication such as **aspirin**, **penicillin**, **Novocain**, or **sulfa**?	16. _____	_____	_____
17. Do you have any other allergies and if so, what? _____	17. _____	_____	_____

CONTINUED ON NEXT PAGE

18. Have you ever been treated for osteoporosis or osteopenia? 18. _____ _____ _____
    If so, has your treatment included any infusions or injections?
19. Do you have either hay fever or asthma? 19. _____ _____ _____
20. Has your weight changed recently? 20. _____ _____ _____
21. Do you have sleep apnea? 21. _____ _____ _____
22. Have you ever been treated for stomach ulcers or stomach trouble? 22. _____ _____ _____
23. Are you on any special type of diet and if so, why? _____ 23. _____ _____ _____
24. When did you last have your teeth cleaned? _____
    Where? _____
25. How frequently have you had your teeth cleaned in the last 10 years? _____
26. Have you had periodontal treatment before and if so, when? _____ 26. _____ _____ _____
    Where? _____
27. Have you ever had orthodontic treatment and if so, when? _____ 27. _____ _____ _____
    Where? _____
28. Indicate approximately the date of your last extraction. _____
29. Do you clench, grit, or grind your teeth? If so, when? _____ 29. _____ _____ _____
30. Do you have any habits such as biting your nails, chewing on pencils or pipe? 30. _____ _____ _____
31. Have you ever used tobacco/vaping products or other substances? 31. _____ _____ _____
    What and how much? _____
32. Are you presently dissatisfied with the appearance of your teeth? 32. _____ _____ _____
    Explain _____
    _____
33. Are you worried about undertaking periodontal treatment? 33. _____ _____ _____

FOR FEMALES ONLY

34. Are you on hormone-based birth control? 34. _____ _____ _____
35. How many pregnancies have you had? _____ How many children do you have? _____
36. If you are now pregnant state month _____ and name of obstetrician _____

PLEASE STATE ANY ADDITIONAL INFORMATION IN YOUR DENTAL OR MEDICAL HISTORY THAT YOU FEEL MAY BE HELPFUL IN DIAGNOSING AND TREATING YOUR CASE. _____

_____

_____

_____

_____

_____

MEDICATIONS, HERBAL SUPPLEMENTS & VITAMINS: _____

_____

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