

Periodontics Medical and Dental History Forms

Personal Information (please click on where applicable and type directly on this form before printing)

Patient's Name: Mr. Mrs. Miss Ms.
How do you prefer to be addressed?
Home Address:
City: Province: Postal Code: Email:
Tel: H: W: ext.: Cell:
Birthdate: M: D: Yr: Age: Birthplace:
Person responsible for this account: Address (if different from above):
Whom can we thank for referring you?:

Insurance Information

Do you have dental insurance? Yes No Name of Insured: Birth Date:
Employer: Address: How Long yrs.
Insurance Company Name:
Policy or Group Number: I.D. or Certificate number:

Medical History

Medical Doctor's Name: Telephone Number: Address:
My Last Physical Examination was on (Date): (M/DN)Results:
Are you being treated by a medical doctor now? Yes No If Yes, for what reason?
Are you taking any medicine at the present time? Yes No If Yes, what?
Do you take aspirin on regular basis? Yes No If Yes, how often
Are you sensitive or allergic to any medication? Yes No If Yes, what?
Have you ever been hospitalized or had any surgical operations? Yes No
If Yes, list reasons and dates:
Have you ever had a blood transfusion? Yes No If Yes, give reason:

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING? (please check if applicable)

- HIV Positive/ Aids High Blood Pressure Osteoporosis Low Blood Pressure
Asthma Stroke Hay Fever Anemia
Tuberculosis Allergies or Hives Rheumatic Fever Ulcers (Stomach or Intestinal)
Scarlet Fever Arthritis Heart Murmur Venereal Disease (Syphilis or Gonorrhea)
Heart Disease Kidney Disease Angina Pectoris Bladder Disease
Hepatitis Gall Bladder Disease Mitral Valve Prolapse Diabetes (Sugar Disease)
Nervousness Epilepsy or Seizures Pacemaker Fainting or Dizzy Spells
Do you bruise easily? Thyroid Disease (Goiter) Do your ankles swell? X-ray or Cobalt Treatment
Chemotherapy (Cancer, Leukemia) Do you have pain in the chest upon exertion?
Do you use extra pillows to sleep? Do you have shortness of breath after mild exercise?
Have you ever had Yellow Jaundice? Do you have to urinate (pass water) more than 6 times a day?
Are you thirsty much of the time? Does your mouth frequently become dry?
Psychiatric Treatment Yes No Have you lost or gained weight (more than 10 pounds) in the past year?
Are you following a diet? Do you have Cataracts or Glaucoma?
Do you have difficulty in swallowing? Has a doctor ever said you have cancer or a tumor?
Do you bleed excessively from a cuts or wounds? Do you have frequent severe headaches?
Do you worry a great deal? Are you under abnormal stress? (For example, marital, business, or social)
Do you feel you need psychiatric care or advice? Do you sometimes take medicine to relieve nervousness?
Do you have any disease, condition, or problem not listed above? If Yes, explain:

Please check if applicable

Do you drink alcohol? How many drinks do you have a day _____ week _____

Do you smoke?

Females

Do you have trouble with your periods? (If you do not menstruate do not check)

Did you have any complications during pregnancy (If you have never been pregnant do not check)

Are you pregnant? Due Date: _____

Are you taking oral contraceptives (Birth control pills)

Dental History

Have you had any serious trouble associated with any previous dental treatment. If Yes, explain: _____

Do you bleed excessively, after tooth extractions?

Have you recently had dental x - rays? If Yes, when: _____

Have you had undesirable reactions to local or general anesthetics? (For example, Novocaine or Gas)

Do you clench or grind your teeth?

Are any of your teeth sensitive to cold or sweets?

Are you dissatisfied with the appearance of your teeth?

Have you had excessive swelling or pain after oral surgery?

Have your teeth been cleaned recently?

Do you have bleeding gums?

Do you have a bad taste in your mouth?

Does food pack between your teeth?

Does your jaw click or pop when you chew?

Have you ever-received treatment for periodontal disease?

Has a dentist ever ground your teeth to correct your bite?

Are you willing to become actively involved in the treatment of your periodontal disease?

Briefly state your feelings toward dentures:

What is your chief complaint concerning your mouth or teeth?

TO THE BEST OF MY KNOWLEDGE ALL OF THE ABOVE ANSWERS ARE TRUE AND CORRECT, IF I HAVE ANY CHANGE IN MY HEALTH, I WILL INFORM DR. LEVY AT MY NEXT APPOINTMENT.

Signature

Date

I hereby acknowledge responsibility for all fees charged for treatment rendered whether covered by my Insurance Co. or not. I also understand that Dr. Levy is a specialist and her fees exceed those of a general dentist. In addition I understand that most Insurance Companies cover procedures up to and not exceeding that of the general dentist. I understand a fee will be charged for missed appointments where at least 48 hours notice is not provided for myself or my children. I also give consent (if Necessary) to photos being taken and used for illustration of my treatment. I consent to submission of my dental claims electronically to my insurance company. I also consent to your collection, of any and all personal information about me including personal health information, and all personal information about any minor of whom I have joint or sole parental custody, and to use such information in any manner or for any purpose whatsoever, but only in the course, of, concerning, or relating to, your dental practice. I similarly consent to the disclosure to third parties of all such information but only in accordance with the Regulated Health Professions, the Dentistry, and Dental Hygiene Acts of Ontario, and to any insurer or other payment organization who may be responsible for payment of all or part of any treatment or service you provide.

Signature

Date