C. Nicholas DeTure, D.M.D.

Diplomate, American Board of Periodontology

PERIODONTICS, IMPLANTS & LASER TREATMENTS

WELCOME

TODAYS DATE:_____ **□ Single □ Married □ Divorced □ Widowed □ Separated**

About You

☐Male☐Female

Name: _____
Last First MI (Mr. Ms. Mrs. Dr.)

Home #: _____ **Cell#**_____ **Work#**_____

Birthdate:_____ **Age:** _____ **Social Sec#:** _____

Home Address: _____

_____

Email: _____

Employer: _____

Phone #: _____

Current Dentist: _____ **PH:** _____

Whom May We Thank for Referring You? _____

Person Responsible for Account

Name: _____

Address:_____

Relationship:_____

Phone: _____

Spouse Information

Name:_____

Home#:_____ **Cell:** _____

Employer:_____

Work#:_____

Birthday: _____

Dental Insurance

Insured's Name: _____

Relation: _____

Insurance Co. Name: _____

Insurance Co. PH#: _____

Group Policy# _____**Group#** _____

Insured's Social Sec#: _____

Insured's Birthday: _____

Insured's ID: _____

What is your primary concern about your mouth?

_____

Do you smoke? Yes/ No

Are you currently in pain? Yes / No

Do you now or have you ever experienced pain/discomfort in your jaw Joint (TMJ)? Yes/ No

Do your gums bleed? Yes/ No

Do you have a water pik? Yes/ No Do you use it? Yes/ No

Have you ever been examined specifically for periodontal disease? If yes by whom? Dr. _____

Do you frequently eat sweets, use mints, or gum? Yes/No

Does the appearance of your teeth bother you? Yes/ No

Have you ever had a serious or difficult problem associated with any previous dental work? Yes/No If yes, what did you have done?

_____

Do you use anything to clean between your teeth? Yes / No If yes, what? _____

When were your teeth last cleaned by a dentist? _____

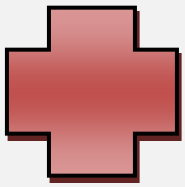
Are you nervous about dental visits? Yes/No

Are you bothered by persistent bad breathe or bad taste in your mouth? Yes/ No

What other information would help us serve you better?

How severe do you consider your gum problem?
☐ Minimal ☐ Moderate ☐ Severe

MEDICAL HISTORY



How would you describe your health?
☐ Excellent ☐ Good ☐ Fair ☐ Poor

Have you ever been hospitalized?
Yes/No If yes, what for? _____

Are you currently under the care of a Physician? Yes/No **Pharmacy #:** _____

If yes, please explain: _____
Physician's Name: _____
Work #: _____

Do you need to Pre-Med before dental visits? Y/N
If yes, what for? _____
What medication do you take? _____

Please list any medications that you are taking Including *ASPIRIN* & *PLAVIX*

_____

Are you Allergic to any of the following drugs?

Are you taking birth control pills? Yes/No

Are you pregnant? Yes/No

Y/N Penicillin Y/N Codeine Y/N Erythromycin
Y/N Tetracycline Y/N Aspirin Y/N Latex
Y/N Barbituates Y/N Sleeping Pills Y/N Dental Anesthetics
Y/N Sedatives Other Allergies: _____

Have you ever had any of the following? Please check and circle:

- ☐ Heart Attack/Stroke
- ☐ Psychiatric Problems
- ☐ Rheumatic Fever
- ☐ Drug/Alcohol Abuse
- ☐ Cancer/Chemotherapy
- ☐ Heart Murmur
- ☐ Mitral Valve Prolapse
- ☐ Diabetes/Tuberculosis (TB)
- ☐ HIV+/AIDS
- ☐ Venereal Disease
- ☐ Hemophilia/Abnormal Bleeding
- ☐ Osteoporosis/Meds for?
- ☐ Ulcers/Colitis
- ☐ Fever Blisters/Shingles
- ☐ Congenital Heart Defect
- ☐ Kidney Problems
- ☐ Anemia/Radiation Treatment
- ☐ Heart Surgery/Pacemaker
- ☐ Epilepsy/Seizure/Fainting Spells
- ☐ Asthma/Arthritis
- ☐ Difficulty Breathing
- ☐ Artificial Bones/Joints
- ☐ Artificial Valves/Stent
- ☐ Sinus Problems/Allergies
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Severe/Frequent Headaches
- ☐ Hepatitis/thyroid Problem
- ☐ Blood Transfusion
- ☐ Ephysema/Glaucoma

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.
I agree to allow photos/videos to be taken and used for educational/promotional purposes.

Signature **Date:**

OFFICE USE ONLY **Medical History Update**

I VERBALLY REVIEWED THE MEDICAL/ DENTAL INFORMATION ABOVE WITH THE PATIENT NAMED HEREIN: Initials Date

1. Date _____ Comments _____ Signature _____
2.Date _____ Comments _____ Signature _____
3.Date _____ Comments _____ Signature _____