

# SPRINGFIELD PERIODONTICS AND DENTAL IMPLANTS

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NAME (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (Middle Initial) \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ ZIP: \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_ age: \_\_\_\_\_ SEX: M F

EMPLOYER \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell/home: \_\_\_\_\_

WHO IS YOUR GENERAL DENTIST? \_\_\_\_\_ PHYSICIAN: \_\_\_\_\_

ARE YOU TAKING ANY MEDICATIONS OR DRUGS: YES/NO If yes please list: \_\_\_\_\_

EMERGENCY CONTACT AND NUMBER \_\_\_\_\_

Are you allergic to any medications? YES/NO Please List: \_\_\_\_\_

Have you ever had or been treated for:

Chest pain	YES	NO	Cancer or tumors	YES	NO
Heart Disease	YES	NO	Radiation/Chemotherapy/Surgical	YES	NO
Pacemaker	YES	NO	Jaundice or Hepatitis	YES	NO
Abnormal blood pressure	YES	NO	Asthma	YES	NO
Ulcers	YES	NO	AIDS or HIV	YES	NO
Tuberculosis or lung Disease	YES	NO	Shortness of breath	YES	NO
Diabetes	YES	NO	Arthritis	YES	NO
Epilepsy or Seizures	YES	NO	Stroke	YES	NO
Anemia	YES	NO	Thyroid Disorder	YES	NO
Kidney Trouble	YES	NO	Joint replacement	YES	NO
Bleeding Problems	YES	NO	Reclast/Bisphosphonates	YES	NO
Drug or alcohol addiction	YES	NO	Any other medical conditions	YES	NO
Major Surgery	YES	NO	What is it		

Do you anticipate becoming pregnant? YES NO Do you take aspirin frequently YES NO

Are you or could you be pregnant? YES NO Do you smoke or chew tobacco YES NO

Reason for visit: \_\_\_\_\_

**Please continue on reverse side**

**DENTAL HISTORY**

When was your last dental visit \_\_\_\_\_ What was done \_\_\_\_\_

When was your last dental cleaning \_\_\_\_\_

Have you ever had any periodontal (gum) treatment: YES NO When \_\_\_\_\_

Have you ever had any problems associated with previous dental treatments: YES NO

If yes, explain: \_\_\_\_\_

How often do you brush your teeth \_\_\_\_\_, Is your brush: Soft Medium Hard

How often do you use dental floss \_\_\_\_\_

Do you use a power toothbrush	YES	NO
Do you use a water flosser	YES	NO
Do you use a proxabrush	YES	NO
Do you use a toothpick	YES	NO
Are you experiencing pain from your mouth currently	YES	NO
Do you have any teeth that are tender to biting or pressure	YES	NO
Has any immediate family member lost all their teeth or had periodontal disease	YES	NO
Do your gums bleed	YES	NO
Do you have any teeth sensitive to hot, cold or sweets	YES	NO
Do you have any loose teeth	YES	NO
Do you clench or grind your jaws while sleeping or during the day	YES	NO
Do you have any difficulty opening or closing your mouth	YES	NO
Does your jaw hurt? Pop? Click?	YES	NO
Do you form calculus (tartar) rapidly or been told you do	YES	NO
Is there anything that concerns you when you receive dental care	YES	NO

**AUTHORIZATION AND RELEASE**

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any changes in my health, or if my medications change, I will inform the doctor at my next appointment without fail. I also authorize the doctor and/or his assistant to perform an examination and take radiographs (x-rays), study models, photographs or any other diagnostic aids deemed appropriate to make a thorough diagnosis.

I authorize the release of any information regarding my diagnosis and treatment to third party insurance carriers, third party payers and/or other health care practitioners. I also authorize the use of this signature on all insurance submissions.

I understand that my dental insurance carrier may pay less than the actual cost of services. I agree to be responsible for payment for all services rendered on my behalf or on behalf of my dependents. I realize that failure to keep this account current may result in my inability to receive further care in this practice. In the case of default on payment on this account, I agree to pay collection costs incurred in attempting to collect on any outstanding balances.

Patient Signature: \_\_\_\_\_ Date \_\_\_\_\_

Doctor Signature: \_\_\_\_\_ Date \_\_\_\_\_