POST FALLS PERIODONTICS
& IMPLANT DENTISTRY
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PERSONAL HISTORY

Patient Name _____Sex M/F

Social Security Number_____Date of Birth_____

Mailing Address _____City _____State_____ Zip Code_____

E-Mail_____

Home Number_____ Cell Number _____Work Number_____

Receive text correspondence Y/N Receive email correspondence Y/N

Emergency Contact_____ Relationship to Patient _____

Home Number_____ Cell Number_____

Referred By _____ Family Dentist _____

Have you or any member of your family been seen or treated at Post Falls Periodontics? Y/N

PRIMARY DENTAL INSURANCE COVERAGE

Insurance Company _____ Phone Number _____

Subscriber Name _____Group Number _____

ID Number _____Date of Birth _____

Employer _____ Relationship to Subscriber _____

SECONDARY DENTAL INSURANCE COVERAGE

Insurance Company _____ Phone Number _____

Subscriber Name _____Group Number _____

ID Number _____ Date of Birth _____

Employer _____ Relationship to Subscriber _____

I authorize my insurance company benefits to be paid directly to Post Falls Periodontics. I am financially responsible for any balance due, including services exceeding the limitations of my insurance policy. I authorize Post Falls Periodontics or Insurance company to release any information requested for claims.

Signature of Patient or Legal Guardian _____Date_____

PATIENT HEALTH HISTORY

Date_____

Welcome to Post Falls Periodontics! We appreciate the confidence you have placed in us to provide your periodontal needs. To assist us in serving you, please complete the following form. The information is important to your dental health. If there are any changes in your health, please tell us. We are always available to answer any of your questions.

Patient Name_____ Date of Birth _____Age_____

Physician's Name _____ Date of Last Visit to Physician_____

Dentist's Name _____ Date of Last Visit to Dentist_____

Height _____ Weight_____

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? PLEASE CHECK ANY THAT APPLY.

Heart Problems
- ☐ Chest Pain
- ☐ Blood Pressure Problem
- ☐ Heart Murmur
- ☐ Heart Valve Disorder (e.g., MVP)
- ☐ Rheumatic Fever
- ☐ Pacemaker
- ☐ Artificial Heart Valve
- ☐ Previous Heart Attack
- ☐ Fast Heart Rate
- ☐ Other_____

Blood Problems
- ☐ Bruise Easily
- ☐ Abnormal Bleeding
- ☐ Blood Disease (e.g. anemia)
- ☐ Other_____

Allergy Problems
- ☐ Hay Fever
- ☐ Sinus Problems
- ☐ Asthma
- ☐ Other_____

Intestinal Problems
- ☐ Ulcer
- ☐ Hiatal Hernia
- ☐ Other_____

Bone or Joint Problems
- ☐ Arthritis
- ☐ Joint Replacement (e.g., total hip)
  Date_____
- ☐ Other_____

Lung/Breathing Problems
- ☐ Emphysema
- ☐ Tuberculosis
- ☐ Shortness of Breath
- ☐ Problems Lying Flat
- ☐ Other_____

Liver Problems
- ☐ Hepatitis
- ☐ Jaundice
- ☐ Other_____

Other Medical Problems
- ☐ Fainting Spells, Seizures, Epilepsy, or Stroke
- ☐ Diabetes
- ☐ HIV Positive
- ☐ Glaucoma
- ☐ Cancer/Tumor
- ☐ Radiation Treatment
- ☐ Surgery in the last 6 months
  Date & Type_____

Social History
- ☐ Do you drink? If so, how much?_____
- ☐ Do you smoke? If so, how much?_____
  How many years?_____
- ☐ Do you chew tobacco? How often?_____

Are you allergic or have had a reaction to any of the following?
- ☐ Local anesthetics ("Novocaine")
- ☐ Penicillin or other Antibiotics_____
- ☐ Sulfa Drugs
- ☐ Barbiturates, Sedatives, or Sleeping Pills
- ☐ Aspirin
- ☐ Codeine
- ☐ Valium
- ☐ Demerol
- ☐ Other_____

List of Medications taken daily and PRN

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Women

- ☐ Are you taking contraceptives?
- ☐ Hormone Replacement Therapy?
- ☐ Is there a possibility you may be pregnant?

  No_____

  Yes _____ Date of Delivery_____

DENTAL HEALTH HISTORY

Please Mark Any That Apply to You

- ☐ Are you apprehensive about dental treatment?
- ☐ Have you had previous periodontal treatment?
- ☐ Do your gums bleed when you brush and floss?
- ☐ Do your gums feel swollen or tender?
- ☐ Are your teeth sensitive?
- ☐ Do you take fluoride supplements?
- ☐ Do you prefer to save your teeth?
- ☐ Do you want complete dental care?
- ☐ How often do you brush?_____ How often do you floss?_____
- ☐ Type of Brush: Standard_____ Sonicare_____ Other (electric)_____
- ☐ Does your jaw make noise?
- ☐ Do you clench or grind your teeth?
- ☐ Does your jaw get stuck so that you cannot open freely?
- ☐ Do you have any jaw symptoms or headaches?
- ☐ Does jaw pain or discomfort affect your appetite, sleep, daily routine or other activities?
- ☐ Do you have a temporomandibular joint disorder (TMD, TMJ)?
- ☐ Are you unable to open your mouth as far as you want?
- ☐ Are you a habitual gum chewer or pipe smoker?
- ☐ Do you have any disease, condition, or problem not listed previously that you feel we should know about?

  If so, please describe:_____

Date:_____ Patient Signature:_____ Dr. Signature_____

DENTIST COMMENTS

Date	Blood Pressure Reading	Medical History Updated
_____	_____	Date_____
_____	_____	Date_____
_____	_____	Date_____
_____	_____	Date_____
_____	_____	Date_____
_____	_____	Date_____
_____	_____	Date_____
_____	_____	Date_____