

Patient Questionnaire (Periodontal)

Form PERIOQ

This questionnaire was designed to provide important facts regarding the history of your pain or condition. The information you provide will assist in reaching a diagnosis. Please take your time and answer each question as completely and honestly as possible. Please sign each page.

PATIENT INFORMATION

TODAY'S DATE _____

MR. MS. MISS MRS. DR. NAME: _____
First Middle Initial Last

AGE: _____ BIRTH DATE: _____ MALE FEMALE

ADDRESS: _____ CITY/STATE/ZIP: _____

EMPLOYED BY: _____

ADDRESS: _____

SS#: _____ HOME PHONE: _____ WORK PHONE: _____

CELL PHONE: _____ EMAIL: _____

MARITAL STATUS: Single Married Widowed Divorced Other

RESPONSIBLE PARTY: _____

FAMILY DENTIST: _____

ADDRESS: _____

FAMILY PHYSICIAN: _____

ADDRESS: _____

REFERRED BY: _____

Dental Concerns

Gum Health

Y N Bleeding
Y N Sore or sensitive
Y N Swollen gums

Other

Y N Dry mouth
Y N Altered taste
Y N Mouth sores
Y N Mouth lesions
Y N Mouth odor
Y N Tooth grinding

Y N Are you here only for a "Periodic Examination"?

Other concerns or reasons for visit: _____

Allergens

Y N Antibiotics
Y N Aspirin
Y N Barbiturates
Y N Codeine
Y N Iodine
Y N Latex
Y N Local anesthetics
Y N Metals
Y N Penicillin
Y N Sedatives
Y N Sulfa drugs
Y N Tetracycline

Other allergens

Patient Signature _____

Date _____

Dental and Medical History

- | | | |
|--|--|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N Arteriosclerosis | <input type="checkbox"/> Y <input type="checkbox"/> N Hay fever | <input type="checkbox"/> Y <input type="checkbox"/> N Osteoporosis |
| <input type="checkbox"/> Y <input type="checkbox"/> N Artificial joint replacement | <input type="checkbox"/> Y <input type="checkbox"/> N Heart disorder | <input type="checkbox"/> Y <input type="checkbox"/> N Pain in cheeks or temples |
| <input type="checkbox"/> Y <input type="checkbox"/> N Asthma | <input type="checkbox"/> Y <input type="checkbox"/> N Heart murmur | <input type="checkbox"/> Y <input type="checkbox"/> N Periodontal bone grafts |
| <input type="checkbox"/> Y <input type="checkbox"/> N Autoimmune disorders | <input type="checkbox"/> Y <input type="checkbox"/> N Heart pacemaker | <input type="checkbox"/> Y <input type="checkbox"/> N Periodontal gum surgery |
| <input type="checkbox"/> Y <input type="checkbox"/> N Bleeding easily | <input type="checkbox"/> Y <input type="checkbox"/> N Heart valve replacement | <input type="checkbox"/> Y <input type="checkbox"/> N Periodontal scaling and root planing |
| <input type="checkbox"/> Y <input type="checkbox"/> N Blood clots | <input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis | <input type="checkbox"/> Y <input type="checkbox"/> N Poor circulation |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cancer | <input type="checkbox"/> Y <input type="checkbox"/> N High blood pressure | <input type="checkbox"/> Y <input type="checkbox"/> N Radiation therapy |
| <input type="checkbox"/> Y <input type="checkbox"/> N Chemotherapy | <input type="checkbox"/> Y <input type="checkbox"/> N Immune system disorder | <input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic fever |
| <input type="checkbox"/> Y <input type="checkbox"/> N Congestive heart failure | <input type="checkbox"/> Y <input type="checkbox"/> N Implants to replace missing teeth | <input type="checkbox"/> Y <input type="checkbox"/> N Shortness of breath |
| <input type="checkbox"/> Y <input type="checkbox"/> N Current pregnancy | <input type="checkbox"/> Y <input type="checkbox"/> N Injury to | <input type="checkbox"/> Y <input type="checkbox"/> N Sleep apnea |
| <input type="checkbox"/> Y <input type="checkbox"/> N Damaged heart valves | <input type="checkbox"/> Mouth <input type="checkbox"/> Teeth | <input type="checkbox"/> Y <input type="checkbox"/> N Stroke |
| <input type="checkbox"/> Y <input type="checkbox"/> N Diabetes | <input type="checkbox"/> Y <input type="checkbox"/> N Insomnia | <input type="checkbox"/> Y <input type="checkbox"/> N Systemic pulmonary shunt |
| <input type="checkbox"/> Y <input type="checkbox"/> N Dizziness | <input type="checkbox"/> Y <input type="checkbox"/> N Irregular heart beat | <input type="checkbox"/> Y <input type="checkbox"/> N Thyroid dysfunction |
| <input type="checkbox"/> Y <input type="checkbox"/> N Emphysema | <input type="checkbox"/> Y <input type="checkbox"/> N Kidney diseases | <input type="checkbox"/> Y <input type="checkbox"/> N Tooth grinding |
| <input type="checkbox"/> Y <input type="checkbox"/> N Endocarditis | <input type="checkbox"/> Y <input type="checkbox"/> N Liver problems | |
| <input type="checkbox"/> Y <input type="checkbox"/> N Epilepsy | <input type="checkbox"/> Y <input type="checkbox"/> N Low blood pressure | |
| <input type="checkbox"/> Y <input type="checkbox"/> N Facial pain | <input type="checkbox"/> Y <input type="checkbox"/> N Migraines | |
| <input type="checkbox"/> Y <input type="checkbox"/> N Fibromyalgia | <input type="checkbox"/> Y <input type="checkbox"/> N Mitral valve prolapse | |
| <input type="checkbox"/> Y <input type="checkbox"/> N Frequent sore throats | <input type="checkbox"/> Y <input type="checkbox"/> N Needing extra pillows to help breathing at night | |
| <input type="checkbox"/> Y <input type="checkbox"/> N Gastroesophageal reflux Disease (GERD) | <input type="checkbox"/> Y <input type="checkbox"/> N Osteoarthritis | |
| <input type="checkbox"/> Y <input type="checkbox"/> N Have had a past diagnosis of gum disease | <input type="checkbox"/> Y <input type="checkbox"/> N Osteonecrosis of the jaw (ONJ) | |
| <input type="checkbox"/> Y <input type="checkbox"/> N Have given premature birth | | |

Other health problems or medical conditions

Social History

- Y N Do you smoke? _____ per day (2 packs, 4 cigars, etc)
- Y N Do you use chewing tobacco?

How often do you consume alcohol?

- Never Once a week
- Occasionally Several days a week
- Daily

Does anyone in your family have a history of:

- | | |
|---|---|
| <input type="checkbox"/> Y <input type="checkbox"/> N Gum or periodontal problems | <input type="checkbox"/> Y <input type="checkbox"/> N Cancer |
| <input type="checkbox"/> Y <input type="checkbox"/> N Diabetes | <input type="checkbox"/> Y <input type="checkbox"/> N High blood pressure |
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart disease | <input type="checkbox"/> Y <input type="checkbox"/> N Stroke |

Recent Hospitalization/Surgery

If you have been hospitalized or have had surgery within the last 5 years please enter details. _____

Have you had adverse reactions to any medications? If so, please explain: _____

Current Medications

Please list the names of any medications you are taking - whether prescription or over the counter (include herbal medications & vitamins).

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

- Y N Have you received the intravenous medication known as bisphosphonate? For example, Zomata (IV) (zoledronic acid) or Arida (IM) (pamidronate)
- Y N Have you taken or are you taking the oral medication known as bisphosphonate for osteoporosis or another medical condition? For example, Fosamax (alendronate), Actonel (risedronate) or Boniva (ibandronate sodium)

Patient Signature _____

Date _____

DENTAL INSURANCE INFORMATION

PRIMARY INSURANCE

ADDITIONAL INSURANCE

Name of Insured _____	Name of Insured _____
Relationship to Patient _____	Relationship to Patient _____
Insured's Birthdate _____	Insured's Birthdate _____
Social Security # _____	Social Security # _____
Employer _____	Employer _____
Employer Address _____	Employer Address _____
City _____ State _____ Zip _____	City _____ State _____ Zip _____
Employer Phone # _____	Employer Phone # _____
Date Employed _____	Date Employed _____
Insurance Company _____	Insurance Company _____
Ins. Co. Address _____	Ins. Co. Address _____
City _____ State _____ Zip _____	City _____ State _____ Zip _____
Group # _____	Group # _____
Employee /Cert. # _____	Employee/ Cert. # _____
Deductible _____	Deductible _____
Max. Annual Benefit _____	Max. Annual Benefit _____

AUTHORIZATION

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such Dental care to third party payers and/or other health practitioners.

I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of patient or parent if patient is a minor

Date

FINANCIAL ARRANGEMENTS

For your convenience, we offer the following methods of payment. Please check the option which you prefer.

Cash _____ Personal Check _____ Credit Card: Visa _____ MC _____ Amer Ex _____ Discover _____

Care Credit _____ Capitol One _____

Late Charges
If I do not pay the entire new balance within 60 days of the monthly billing date, a late charge of 1.5 % on the balance then unpaid and owed will be assessed each month (if allowed by law). I realize that failure to keep this account current may result in you being unable to provide additional dental services except for dental emergencies or where there is prepayment for additional services. In the case of default on payment of this account or any future outstanding account balances.