Welcome

Lauren B. Shack, D.D.S.
Palms West Periodontal

PATIENT INFORMATION

Date: ______________________________ Occupation: ______________________________

SS #: ______________________________ Patient Employer/School: ______________________________

Patient Name: ______________________________ Employer/School Address: ______________________________

Address: ______________________________ ______________________________

City: ______________________________ Employer/School Phone: ______________________________

State: ____________ Zip: ____________ Spouse's/Parent/Guardian Name: ______________________________

E-mail: ______________________________ Birthdate: ____________ SS # ____________

Sex ☐ M ☐ F Age: ______ Birthdate: ____________ Spouse's/Parent/Guardian Employer: ______________________________

☐ Married ☐ Widowed ☐ Single ☐ Minor
☐ Separated ☐ Divorced ☐ Partnered

Whom may we thank for referring you? ______________________________

DENTAL INSURANCE

Subscriber's Name: ______________________________

Relationship to Patient: ______________________________

Birthdate: ____________ SS # ____________

Insurance Co.: ______________________________

Group #: ____________ Phone: ____________

Is patient covered by secondary insurance: ☐ Yes ☐ No

Subscriber's Name: ______________________________

Relationship to Patient: ______________________________

Birthdate: ____________ SS # ____________

Insurance Co.: ______________________________

Group #: ____________ Phone: ____________

PHONE NUMBERS

Home: ____________ Work: ____________ Ext.: ______ Cell: ____________

Spouse's Work: ____________ Cell: ____________ Best time and place to reach you: ____________

IN CASE OF EMERGENCY, CONTACT *(Specify someone who does not live in your household.)*

Name: ______________________________ Relationship: ______________________________

Home: ____________ Work: ____________ Ext.: ______ Cell: ____________

DENTAL HISTORY

Reason for today's visit: ______________________________

____

Former Dentist: ______________________________

City/State: ______________________________

Date of last dental visit: ______________________________

Date of last dental X-rays: ______________________________

How often do you floss? ______________________________

How often do you brush? ______________________________

Do you wear contact lenses? ☐ Yes ☐ No

Please check (✓) "yes" or "no" to indicate if you have had any of the following:

Condition	Yes	No
Bad Breath	☐ Yes	☐ No
Bleeding gums	☐ Yes	☐ No
Blisters on lips or mouth	☐ Yes	☐ No
Burning sensation on tongue	☐ Yes	☐ No
Chew on one side of mouth	☐ Yes	☐ No
Cigarette, pipe or cigar smoking	☐ Yes	☐ No
How Much? ____________		
Clicking or popping jaw	☐ Yes	☐ No
Dry mouth	☐ Yes	☐ No
Fingernail biting	☐ Yes	☐ No
Food collection between the teeth	☐ Yes	☐ No
Frequent Headaches	☐ Yes	☐ No
Foreign objects in mouth	☐ Yes	☐ No
Grinding teeth	☐ Yes	☐ No
Jaw pain or tiredness	☐ Yes	☐ No
Lip or cheek biting	☐ Yes	☐ No
Loose teeth or broken fillings	☐ Yes	☐ No
Mouth breathing	☐ Yes	☐ No
Mouth pain	☐ Yes	☐ No
Orthodontic treatment	☐ Yes	☐ No
Pain around ear	☐ Yes	☐ No
Periodontal treatment	☐ Yes	☐ No
Sensitivity to cold	☐ Yes	☐ No
Sensitivity to heat	☐ Yes	☐ No
Sensitivity to sweets	☐ Yes	☐ No
Sensitivity when biting	☐ Yes	☐ No
Sores or growths in mouth	☐ Yes	☐ No

HEALTH HISTORY

Physician's Name: ______________________________ Date of last visit: ______________

Phone: ______________________ Pharmacy: ______________________ Phone: ______________________

Please check (✓) "yes" or "no" to indicate if you have had any of the following:

Condition	Yes	No
AIDS	☐ Yes	☐ No
Alcohol Abuse	☐ Yes	☐ No
Anemia	☐ Yes	☐ No
Arthritis, Rheumatism	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Back Problems	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No
Circulatory Problems	☐ Yes	☐ No
Cortisone Treatments	☐ Yes	☐ No
Cough, persistent or bloody	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Eating Disorder	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No
Epilepsy or Seizures	☐ Yes	☐ No
Fainting or dizziness	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No
Headaches	☐ Yes	☐ No
Heart Problems	☐ Yes	☐ No

Have you ever had any complications following dental treatment? ☐ Yes ☐ No

If yes, please describe________________

____

Have you ever been hospitalized or do you have any other health concerns? ☐ Yes ☐ No

Women: Are you pregnant? ☐ Yes ☐ No

Due date ________________________

	Yes	No
Are you nursing?	☐ Yes	☐ No
Taking birth control pills?	☐ Yes	☐ No

Condition	Yes	No
Hepatitis Type_________	☐ Yes	☐ No
Herpes	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No
HIV Positive	☐ Yes	☐ No
Hypoglycemia	☐ Yes	☐ No
Jaundice	☐ Yes	☐ No
Jaw Pain	☐ Yes	☐ No
Kidney Disease	☐ Yes	☐ No
Liver Disease	☐ Yes	☐ No
Low Blood Pressure	☐ Yes	☐ No
Nervous Problems	☐ Yes	☐ No
Psychiatric Care	☐ Yes	☐ No
Radiation Treatment	☐ Yes	☐ No
Respiratory Disease	☐ Yes	☐ No
Scarlet Fever	☐ Yes	☐ No
Shortness of Breath	☐ Yes	☐ No
Sinus Trouble	☐ Yes	☐ No
Skin Rash	☐ Yes	☐ No
Special Diet/Weight Loss	☐ Yes	☐ No
Stroke	☐ Yes	☐ No

Have you ever taken any of these medications?

Medication	Yes	No
Blood Thinners	☐ Yes	☐ No
Coumadin	☐ Yes	☐ No
Warfarin	☐ Yes	☐ No
Diet Medications	☐ Yes	☐ No
Dexfenfluramine	☐ Yes	☐ No
Fen-phen	☐ Yes	☐ No
Pondimin	☐ Yes	☐ No
Redux	☐ Yes	☐ No
Levoxyl	☐ Yes	☐ No
Synthroid	☐ Yes	☐ No

Condition	Yes	No
Swollen Feet or Ankles	☐ Yes	☐ No
Swollen Neck Glands	☐ Yes	☐ No
Thyroid Problems	☐ Yes	☐ No
Tonsillitis	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No
Tumors or Growths	☐ Yes	☐ No
Ulcer	☐ Yes	☐ No
Venereal Disease	☐ Yes	☐ No

Have you ever had or been diagnosed with:

Condition	Yes	No
Artificial Heart Valves	☐ Yes	☐ No
Artificial Joints, Screws Pins, etc.	☐ Yes	☐ No
Bleeding abnormally, with extractions or surgery	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No
Congenital Heart Lesions	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No
Hernia Repair	☐ Yes	☐ No
Mitral Valve Prolapse	☐ Yes	☐ No
Pacemaker	☐ Yes	☐ No
Rheumatic Fever	☐ Yes	☐ No

Are you allergic to:

Allergen	Yes	No
Aspirin	☐ Yes	☐ No
Barbiturates	☐ Yes	☐ No
Codeine	☐ Yes	☐ No
Ibuprofen	☐ Yes	☐ No
Latex	☐ Yes	☐ No
Local Anesthesia	☐ Yes	☐ No
Metals (i.e. gold)	☐ Yes	☐ No
Penicillin	☐ Yes	☐ No

Other______________________________

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Are you taking any medicine(s) including non-prescription medicine… ☐ Yes ☐ No If yes, what medicine(s) are you taking? (For example, Aspirin or Vitamins)? ______________________________

Have you ever been told by a physician to premedicate with antibiotics before dental visits?… ☐ Yes ☐ No
If yes, what medicine?______________________________

Are you taking or have you ever taken bisphosphonates (Fosamax, Actonel, Boniva for osteoporosis, or intravenous chemotherapy for multiple myeloma or other cancer which spread to the bones?) ☐ Yes ☐ No

List:______________________________

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NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: ______________________________Date:________________

FOR COMPLETION BY DENTIST

Comments: ______________________________

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