

**Patient Information Form - Confidential**

Name \_\_\_\_\_ Nickname \_\_\_\_\_ ( ) Male ( ) Female  
 Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_ E-mail \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_ Occupation \_\_\_\_\_  
 Employer \_\_\_\_\_ Whom may we thank for referring you? \_\_\_\_\_  
 Emergency Contact \_\_\_\_\_ Phone # \_\_\_\_\_ Relationship to you \_\_\_\_\_

Primary Dental Insurance \_\_\_\_\_ ID# \_\_\_\_\_ Group# \_\_\_\_\_  
 Whose name is the insurance under \_\_\_\_\_ Relationship to you \_\_\_\_\_  
 Subscriber's Date of Birth \_\_\_\_\_ Insured person's employer \_\_\_\_\_ City \_\_\_\_\_

Prior Dentist \_\_\_\_\_ City \_\_\_\_\_ Phone \_\_\_\_\_  
 When was your last cleaning & exam? \_\_\_\_\_ last x-ray? \_\_\_\_\_ How many times a day do you Brush/Floss? \_\_\_\_\_ / \_\_\_\_\_  
 Are you currently experiencing any tooth pain, TMJ, bleeding gums, etc? Explain \_\_\_\_\_  
 Are you concerned about color or staining of your teeth? **YES NO** Do you or have you ever smoked? **YES NO**  
 Has your physician ever recommended that you take prophylaxis antibiotics prior to dental treatment? **YES NO**  
 If above YES, explain \_\_\_\_\_  
 Have you ever taken the following drugs: Fosamax, Actonel, Boniva, Skelid, Didronel? **YES NO** Explain \_\_\_\_\_  
 Have you had chemotherapy with Aredia or Zometa? **YES NO** Explain \_\_\_\_\_  
 Do you have an allergy to Latex? **YES NO** Do you have an allergy to metal or jewelry? **YES NO** Which: \_\_\_\_\_

Primary Physician \_\_\_\_\_ Phone # \_\_\_\_\_  
 Are you taking any prescription/over-the-counter drugs? **YES NO** List Medications and duration \_\_\_\_\_

Are you allergic to any medications? **YES NO** Explain \_\_\_\_\_  
 Are you allergic to anesthesia? **YES NO** Date of last physical exam? \_\_\_\_\_  
 Please list dates of hospitalizations and reasons \_\_\_\_\_

- HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING ?** Please circle one **Y** (yes) or **N** (no)
- |                                |   |   |   |
|--------------------------------|---|---|---|
| <b>Y N</b> Allergies           | <b>Y N</b> Epilepsy/Seizures/Faint Spells | <b>Y N</b> High Blood Pressure          | <b>Y N</b> Mononucleosis                        |
| <b>Y N</b> Artificial Joints   | <b>Y N</b> Frequent /Severe Headaches     | <b>Y N</b> Infectious Disease/AIDS/HIV+ | <b>Y N</b> Pneumonia                            |
| <b>Y N</b> Arthritis           | <b>Y N</b> Ulcers/Colitis                 | <b>Y N</b> Jaundice                     | <b>Y N</b> Rheumatic Fever                      |
| <b>Y N</b> Asthma              | <b>Y N</b> Stomach Ulcers                 | <b>Y N</b> Kidney Problems              | <b>Y N</b> Scarlet Fever                        |
| <b>Y N</b> Bleeding Gums       | <b>Y N</b> Heart Attack/Stroke            | <b>Y N</b> Liver Problems               | <b>Y N</b> Shingles                             |
| <b>Y N</b> Cancer/Chemotherapy | <b>Y N</b> Heart Murmur                   | <b>Y N</b> Low Blood Pressure           | <b>Y N</b> Sinus Problems                       |
| <b>Y N</b> Chest Pain          | <b>Y N</b> Heart Problems                 | <b>Y N</b> Taken Phen-fen diet pills    | <b>Y N</b> Small Pox                            |
| <b>Y N</b> Chicken Pox         | <b>Y N</b> Heart Surgery/Pacemaker        | <b>Y N</b> Pregnancy                    | <b>Y N</b> Tuberculosis                         |
| <b>Y N</b> Diabetes            | <b>Y N</b> Hemophilia/Abnormal Bleeding   | <b>Y N</b> Measles                      | <b>Y N</b> Cough Producing Blood                |
| <b>Y N</b> Emotional Condition | <b>Y N</b> Hepatitis A, B, or C           | <b>Y N</b> Mitral Valve Prolapse        | <b>Y N</b> Persistent Cough Longer than 3 weeks |

Please explain any "YES" responses \_\_\_\_\_  
**Any other medical/dental problems not mentioned above?** \_\_\_\_\_

*I understand that the information I have given today is correct to the best of my knowledge. I understand this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical/dental status. I authorize the release of dental information necessary to process claims for dental benefits. I authorize payment of dental benefits to Gruskowski Dental Associates. I understand that the patient is responsible for any and all charges not covered by the dental insurance carrier.*

*I understand that payment is due in full at the time of service. It is the policy of this office that the adult presenting the child for treatment is responsible for payment of the patient portion at the time of service. If the child is covered under an adult's dental insurance, that adult is responsible for payment of the patient portion at the time of service.*

*A finance charge of 1.5% will be added to all unpaid bills over 30 days. I understand that I may be charged a \$50 broken appointment fee for all appointments cancelled less than 24 hours.*

Signature of Patient or Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_ Pharmacy \_\_\_\_\_  
 Location \_\_\_\_\_  
 Phone # \_\_\_\_\_

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**DENTAL HISTORY**

How can I help \_\_\_\_\_  
 Has dental care been regular \_\_\_\_\_  
 Has anyone in family ever lost all of their teeth \_\_\_\_\_  
 Spouse's habits \_\_\_\_\_ Children's Habits \_\_\_\_\_  
 What do you think of your present dental health \_\_\_\_\_  
 Do you think it's possible to keep your teeth for a lifetime \_\_\_\_\_  
 How would you feel if you ever had to lose all of your teeth \_\_\_\_\_  
 What do you do to care for your teeth \_\_\_\_\_  
 How dentistry should work and the main goal of my practice \_\_\_\_\_

**CLINICAL EXAMINATION**

Missing teeth <u>See Charting</u> _____	Any unmanageable bacterial traps _____
Why lost _____	Palpation of roots _____
Replacements _____	Height of muscle attachments _____
Broken fillings _____	Width of attached gingiva _____
Margins of old fillings _____	Areas of heavy bacterial accumulations _____
Potential cusp fracture areas _____	Any loss of papillae _____
Any poor contacts _____	Any recession <u>See Charting</u> _____
Location of cavities <u>See Charting</u> _____	Any erosion or abrasion _____
Any unmanageable teeth _____	Probe for pocket depths <u>See Charting</u> _____
Discolored anterior teeth _____	Any bleeding gums <u>See Charting</u> _____
Abraded anterior teeth _____	Color of gingival tissues _____
Spaces anterior teeth _____	State of sulcular epithelium _____
Crowded anterior teeth _____	Mobilities <u>See Charting</u> _____

**OCCLUSION**

Class _____	Bruxism _____
Right Working _____ Balancing _____	Right Joint Pain _____
Left Working _____ Balancing _____	Left Joint pain _____
Protrusive Contacts _____	Left crepitus _____
Prematurities _____	Right crepitus _____
Right chewing efficiency _____	Deviation on opening _____
Left chewing efficiency _____	Reverse swallow _____

**SOFT TISSUE**

0 = none      1 = slight      2 = moderate      3 = extensive

Lymph Nodes: Submandibular \_\_\_\_\_ Anterior Cervical \_\_\_\_\_  
 Lips: Dryness \_\_\_\_\_ Hyperkeratosis \_\_\_\_\_ Cheilosis \_\_\_\_\_ Swelling \_\_\_\_\_  
 Buccal & Labial Mucosa: Keratosis \_\_\_\_\_ Ulceration \_\_\_\_\_ Swelling \_\_\_\_\_  
 Palate: Hyperkeratosis \_\_\_\_\_ Torus \_\_\_\_\_ Ulceration \_\_\_\_\_  
 Fauces: Inflamed \_\_\_\_\_ Lesions \_\_\_\_\_  
 Tongue: Coating \_\_\_\_\_ Fissuring \_\_\_\_\_ Anthropic areas \_\_\_\_\_  
           Pallor \_\_\_\_\_ Erythema \_\_\_\_\_ Indentations \_\_\_\_\_  
 Floor of mouth: Salivary gland enlargement \_\_\_\_\_ Lesions \_\_\_\_\_  
                           Swelling \_\_\_\_\_ Tori \_\_\_\_\_  
 Saliva: Viscous \_\_\_\_\_ Flow \_\_\_\_\_  
 Fetor Oris: \_\_\_\_\_

**GENERAL CONDITION OF MOUTH**

State of Active Disease: Cavities: Active \_\_\_\_\_ Limited \_\_\_\_\_  
 Gum Disease: Very Active \_\_\_\_\_ Active \_\_\_\_\_ Limited \_\_\_\_\_ None \_\_\_\_\_  
 State of Bacterial Control \_\_\_\_\_ State of Manageability \_\_\_\_\_