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 dugs: 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)

Y N Allergies	**Y N** Epilepsy/Seizures/Faint Spells	**Y N** High Blood Pressure	**Y N** Mononucleosis
Y N Artificial Joints	**Y N** Frequent /Severe Headaches	**Y N** Infectious Disease/AIDS/HIV+	**Y N** Pneumonia
Y N Arthritis	**Y N** Ulcers/Colitis	**Y N** Jaundice	**Y N** Rheumatic Fever
Y N Asthma	**Y N** Stomach Ulcers	**Y N** Kidney Problems	**Y N** Scarlet Fever
Y N Bleeding Gums	**Y N** Heart Attack/Stroke	**Y N** Liver Problems	**Y N** Shingles
Y N Cancer/Chemotherapy	**Y N** Heart Murmur	**Y N** Low Blood Pressure	**Y N** Sinus Problems
Y N Chest Pain	**Y N** Heart Problems	**Y N** Taken Phen-fen diet pills	**Y N** Small Pox
Y N Chicken Pox	**Y N** Heart Surgery/Pacemaker	**Y N** Pregnancy	**Y N** Tuberculosis
Y N Diabetes	**Y N** Hemophilia/Abnormal Bleeding	**Y N** Measles	**Y N** Cough Producing Blood
Y N Emotional Condition	**Y N** Hepatitis A, B, or C	**Y N** Mitral Valve Prolapse	**Y N** 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 See Charting_____

Why lost _____

Replacements _____

Broken fillings _____

Margins of old fillings_____

Potential cusp fracture areas_____

Any poor contacts _____

Location of cavities See Charting_____

Any unmanageable teeth_____

Discolored anterior teeth _____

Abraded anterior teeth _____

Spaces anterior teeth _____

Crowded anterior teeth _____

Any unmanageable bacterial traps _____

Palpation of roots _____

Height of muscle attachments _____

Width of attached gingiva _____

Areas of heavy bacterial accumulations _____

Any loss of papillae _____

Any recession See Charting_____

Any erosion or abrasion _____

Probe for pocket depths See Charting_____

Any bleeding gums See Charting_____

Color of gingival tissues_____

State of sulcular epithelium _____

Mobilities See Charting_____

OCCLUSION

Class _____

Right Working _____ Balancing _____

Left Working _____ Balancing _____

Protrusive Contacts _____

Prematurities _____

Right chewing efficiency _____

Left chewing efficiency _____

Bruxism _____

Right Joint Pain _____

Left Joint pain _____

Left crepitus _____

Right crepitus _____

Deviation on opening _____

Reverse swallow_____

SOFT TISSUE

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

Lymph Nodes: Submandibular _____ Anterior Cervical _____

Lips: Dryness _____ Hyperkeratosis _____ Cheilosis _____ Swelling _____

Bucccal & 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 _____