MT IMPLANTS AND PERIO

Dr. Jaden Erwin DDS, MSD

ABOUT YOU:

Today's Date: _____

Name: _____

Last First MI

I Prefer to Be Called: _____

Date of Birth: _____ Age: _____ Sex: _____

Social Security #:_____

Single Married Divorced Widowed Separated

Mailing Address: _____

_____

City: _____ State: _____ Zip: _____

Cell Phone #:_____

Home Phone #:_____

Work Phone #:_____

Email Address: _____

Electronic Appointment Reminder (*circle all that apply*)

Text Message Email Phone Call

Employer: _____

How long there? _____Occupation:_____

Person responsible for your account? (*If Not Yourself*)

Name: _____ Preferred Phone #: _____

PRIMARY INSURANCE HOLDER'S INFORMATION:

(If NOT yourself)

Name: _____

Employer: _____

Preferred Phone #:_____

SS#:_____ Date of Birth: _____

SECONDARY INSURANCE HOLDER'S INFORMATION:

(If NOT yourself OR primary)

Name: _____

Employer: _____

Preferred Phone #:_____

SS#:_____ Date of Birth: _____

DENTAL INSURANCE CARD INFORMATION:

(If you have provided us with your card(s) you can skip this box)

Primary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

_____

Insurance Co. Phone#: _____

Group # (Plan, Local or Policy #):_____

Secondary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

_____

Insurance Co. Phone#: _____

Name of pharmacy you use: _____

What city is this pharmacy located? _____

Y / N Is this the pharmacy you would like us to use?

If no, which pharmacy would you like us to use? _____

What city is this pharmacy located? _____

DENTAL HISTORY:

Referring Dentist:_____

How long have you seen referring dentist? _____

What is your "chief complaint"? _____

_____

Y / N Are you having any discomfort at this time?

If yes, please explain:_____

Y / N Are you taking any medication for "chief complaint"?

If yes, please explain:_____

Y / N Have you ever had any serious trouble associated with previous dental treatment?

If yes, please explain:_____

Does dental treatment make you nervous? (*circle all that apply*)

No Slightly Moderately Extremely

Have you had any of the following? (*circle all that apply*)

Deep cleanings Periodontal surgery 3 month cleanings

How many times a day do you brush?

How many times a week do you floss?

Brush type: ☐ Soft ☐ Medium ☐ Hard

☐ Electric ☐ Manual

Do you have or have you ever had any of the following?

MOUTH	TEETH
Y / N Bleeding, sore gums	Y / N Loose teeth
Y / N Unpleasant taste/bad breath	Y / N Sensitive to hot
Y / N Burning tongue/lips	Y / N Sensitive to cold
Y / N Frequent blisters, lips/mouth	Y / N Sensitive sweets
Y / N Swelling/lumps in mouth	Y / N Sensitive biting
Y / N Ortho treatment (braces)	Y / N Food impaction
Y / N Biting cheeks/lips	Y / N Clench/grinding
Y / N Clicking/Popping jaw	If yes, when?_____
Y / N Difficulty opening or closing	
Y / N Change or shifting of the bite	

Do you use the following? (*circle all that apply*)

☐ Perio aid ☐ Proxabrush ☐ Fluoride

EMERGENCY CONTACT:

Name: _____ Relation: _____

Preferred Phone #:_____

HISTORY:

Do you have a personal physician? Yes No
Physician's Name: _____

Additional Names: _____

_____

Y / N Has there been any change in your health recently?
If yes, please explain:

_____

Y / N Are you currently under the care of a physician?
If yes, please explain:

_____

Y / N Are you taking any medications?

Medication Name:	**Purpose:**
_____	_____
_____	_____
_____	_____
_____	_____

Y / N Do you take aspirin daily?

Y / N Do you pre-medicate (antibiotics) prior to dental visits?
If yes, please explain: _____

ALLERGIES:

Are you ALLERGIC or have you reacted adversely:

Y / N	Penicillin	Y / N	Sulfa
Y / N	Tetracycline	Y / N	Latex
Y / N	Erythromycin	Y / N	Iodine
Y / N	other antibiotics	Y / N	Aspirin
Y / N	Local anesthetics	Y / N	Codeine
Y / N	Barbiturates / Sedatives	Y / N	Other
Y / N	Narcotics		

Comments/other drug reactions: _____

_____

TOBACCO /ALCOHOL:

Y / N Do you use tobacco products?
If yes, how much per day and what:
Cigarettes ____ Cigars _____ Pipe____ Smokeless____
Y / N Do you consume alcoholic beverages?
If yes, how much per day and what:
_____

STRESS / ANXIETY:

Y / N Are you experiencing unusual amounts of stress or pressure at work or home?
Comments: _____

_____

WOMEN:

Y / N Are you pregnant?
Y / N Are you taking birth control or hormone therapy?

_____

Cardiovascular:

Y / N	Heart failure	Y / N	Heart disease
Y / N	Angina or chest pains	Y / N	Heart attack
Y / N	High blood pressure	Y / N	Mitral valve prolapse
Y / N	Congenital heart defect	Y / N	Rheumatic fever
Y / N	Heart surgery	Y / N	Heart murmur/click
Y / N	Irregular beat/arrhythmia	Y / N	Artificial heart valve
Y / N	Pacemaker/defibrillator		

Genito-Urinary / Endocrine:

Y / N	Diabetes	Y / N	Bladder problems
Y / N	Dialysis	Y / N	Kidney problems
Y / N	Thyroid disease		
Y / N	Sexually transmitted disease: Date_____		
	(*Syphilis, gonorrhea, Chlamydia, herpes, HIV, Aids, etc.*.)		

Respiratory:

Y / N	Sinus trouble	Y / N	Hay fever
Y / N	Asthma	Y / N	Persistent cough
Y / N	Bronchitis	Y / N	Breathing difficulties
Y / N	Emphysema	Y / N	Sleep Apnea
Y / N	Tuberculosis (TB)		

Dermal / Oral /Musculoskeletal:

Y / N	Allergy to latex (rubber)	Y / N	Skin rash or hives
Y / N	Arthritis or rheumatism	Y / N	Artificial joint
Y / N	Fever blisters	Y / N	Mouth ulcers
Y / N	Canker sores		

Neural:

Y / N	Stroke	Y / N	Vision problems
Y / N	Glaucoma or cataract	Y / N	Earaches/ringing ears
Y / N	headaches/Migraine	Y / N	Fainting/dizzy spells
Y / N	Epilepsy or seizures	Y / N	Nervousness
Y / N	Psychiatric treatment		

Hematological:

Y / N	Blood transfusion	Y / N	Sickle cell anemia
Y / N	Anemia	Y / N	Hemophilia
Y / N	Leukemia		
Y / N	Tendency to bleed longer than normal		

Gastrointestinal:

Y / N	Stomach / intestine ulcer	Y / N	Colitis
Y / N	Esophageal reflux GERD	Y / N	Persistent diarrhea
Y / N	Hepatitis or jaundice	Y / N	Cirrhosis
Y / N	Other liver problems		

Cancer or chemotherapy:

Y / N	Tumor or cancer	Y / N	Chemotherapy
Y / N	X-ray or radiation		

Other:

Y / N Enlarged lymph node or "gland"
Y / N Any other conditions: _____

_____

The information I have provided is correct to the best of my knowledge. If my health changes in any way, I am aware that it is my responsibility to personal inform Dr. Walters, Dr. Erwin & Dr. Swoboda.

_____
(Patient Signature) (Date)

_____
(Parent/Legal Guardian) (Date)