BELMONT PERIODONTICS, P.C.

Practice Limited to Periodontics, Dental Implants & Oral Diagnosis

http://www.belmontperiodontics.com

Welcome to Our Office

Patient Registration ✐

Name ____ Home Phone _(_____)_______-__________
First Middle Last

Address __________________________________ City ____________________ Zip Code _____________

Date of Birth ____/____/____ Social Security # ______-_____-_______ Marital Status: single ❑, married ❑, child ❑, other ❑

How would you like to be addressed? ______________________________________

Employer ____________________ Occupation _________________ Work Phone _(_____)_____-_______ ext.____

E-mail ____________@______________ Fax # _(_____)_______-__________ Mobile # _(_____)_______-________

Name of Spouse or Closest relative ______________________ Phone if Different _(_____)_______-__________

Spouse's Employer ____________________ Occupation __________________ Date of Birth ____/____/____

Dental Insurance _________________________ Policy #__________________ Group #_______________

Relation to Subscriber: self ❑, spouse ❑, child ❑, other ❑ (Please provide insurance card if available)

Name and address of your dentist ____

Health Questionnaire

Since the cause of periodontal disease is a combination of many factors, it is necessary to investigate any and all possible contributing influences. Although many of these questions may not directly relate to your particular oral condition, they are all related to possible contributing factors.

Please answer all the questions or circle ***Yes*** or ***No***, whichever applies. Your answers are for our records only and will be kept confidential.

PRESENT HEALTH

1. Are you in good health? .... Yes No
2. Has there been any change in your health within the past year? .... Yes No
3. Are you under the care of a physician for a specific health problem? .... Yes No
4. Name and address of your physician(s) ____
5. Date of your last physical exam ______________________
6. What medications, or drugs of any kind, are you presently taking? ___________________________

PAST MEDICAL HISTORY

7. Have you had any serious illness or operation? .... Yes No
   If so, what was the illness or problem, and when? ____
8. Have you ever taken steroids or blood thinners? .... Yes No
9. Are you allergic or have you ever had any adverse reactions to any medications or drugs? ..... Yes No
   If so, which ones? ____
10. Have you ever had any allergies to plants, animals, or foods? .... Yes No

CARDIOVASCULAR

11. Have you ever had any heart trouble (including murmurs or prosthetic heart valves)? .... Yes No
12. Has your blood pressure ever been too high or too low? .... Yes No
13. Have you ever had rheumatic fever or rheumatic heart disease? .... Yes No
14. Are you subject to fainting spells? .... Yes No

BLOOD

15. Have you had abnormal bleeding? .... Yes No
16. Do you have any blood disorder such as anemia? .... Yes No
17. Have you ever been told not to donate blood? .... Yes No

ENDOCRINE

18. Do you or any member of your immediate family have diabetes? .... Yes No
19. Have you ever been treated for thyroid problems? .... Yes No
20. Have you ever been treated for any other endocrine or glandular disorder? .... Yes No

Please complete opposite side of form

G.I. and G.U.

21. Have you ever had jaundice, hepatitis, or liver disease? ……………………………………… Yes No
22. Have you ever had any gastrointestinal disorder including an ulcer? ………………………… Yes No
23. Do you have any kidney problems? ……………………………………………………………... Yes No
24. Have you ever had a sexually transmitted disease? …………………………………………... Yes No
25. Are you on any special diet? …………………………………………………………………….. Yes No
26. Has your consumption of alcohol beverages ever been a problem?………………….……… Yes No

RESPIRATORY

27. Do you ever become short of breath? ………………………………………………………… Yes No
28. Do you suffer from sinus trouble? ……………………………………………………………. Yes No
29. Do you have frequent colds that keep you out of work? ……………………………………... Yes No
30. Have you had tuberculosis or a persistent cough? ……………………………………………. Yes No
31. Do you have emphysema, bronchitis, or asthma? ……………………………………………. Yes No
32. Do you breathe primarily through your mouth? ……………………………………………… Yes No
33. Do you now, or have you ever smoked (or used smokeless tobacco)? ..………….……….. Yes No
    How much? __________________ When? ___________________ For how long? ______________

NERVOUS

34. Do you suffer frequent or severe headaches? ………………………………………………… Yes No
35. Have you ever had severe pains of the head or face? ………………………………………… Yes No
36. Have you ever had epilepsy or convulsions? ………………………………………………… Yes No
37. Are you under extreme tension? ……………………………………………………………… Yes No
38. Do you consider yourself excessively nervous? ……………………………………………… Yes No
39. Do you now or have you had problems with mental health? ………………………………… Yes No

OTHER

40. Have you ever received radiation or radioactive isotope therapy? …………………………… Yes No
41. Have you ever been treated for any skin disease? ……………………………………………. Yes No
42. Have you ever been diagnosed with a tumor or cancer? ……………………………………… Yes No
43. Have you ever tested positive for HIV or AIDS? …………………………………………….. Yes No
44. Do you have arthritis, painful swollen joints, or a prosthetic joint replacement? ……………. Yes No

FEMALES

45. Are you now pregnant, nursing, or anticipating pregnancy within the next year? …………... Yes No
46. Are you taking birth control pills? ……………………………………………………………. Yes No
47. Have you undergone or are you presently undergoing menopause? …………………………. Yes No

PRESENT DENTAL HEALTH

48. Do your gums tend to bleed? …………………………………………………………………. Yes No
49. Are you frequently aware of a bad taste or odor in your mouth? …………………………….. Yes No
50. Does your jaw ever click or cause pain on opening or closing? ……………………………… Yes No
51. Have you noticed any shift in your teeth or bite? …………………………………………….. Yes No
52. Do you chew on one side of your mouth? ……………………………………………………. Yes No
53. Is any area of your mouth sore to pressure or sensitive to hot or cold? ……………………… Yes No
54. Have you ever noticed yourself clenching your teeth? ……………………………………….. Yes No
55. Have you ever been told that you grind your teeth at night? …………………………………. Yes No
56. Do you suffer from frequent gum boils, canker sores, or cold sores? ………………………… Yes No
57. Did you ever have braces (orthodontics)? ……………………………………………………... Yes No
58. Have you ever had gum treatments (periodontics)? …………………………………………..… Yes No
59. Is there a family history of gum disease? ……………………………………………………... Yes No
60. Have you had a full mouth series of dental x-rays taken within the last five years? ………… Yes No
61. How long ago was your last dental cleaning? ________________ Before that? ____________________
62. Do you have a significant fear of the dentist to the extent that it may interfere with treatment? .Yes No
63. Have you ever had any serious problems associated with previous dental treatment? ………... Yes No
    If so, explain ____
64. Do you have any disease, condition, or problem not listed above that you think that we should know about? If so, please explain ____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth have been answered to my satisfaction. I will not hold Dr. Orr, or any other member of his staff, responsible for any errors or omissions that I may have made in the completion of this form. I understand that it is my responsibility to inform this office of any changes in my medical status. I authorize Dr. Orr and his staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment. I acknowledge receipt of Notice of Privacy Practices, posted in the reception room. By signing this form, I consent to the use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations. I understand that I am responsible for all fees, regardless of insurance coverage.

Patient (Parent or Guardian) **Signature**________________________________ Date___________________

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