DENTAL HISTORY

Describe your chief complaint: _____

When was your last dental visit? _____ Dental Cleaning?_____

How frequently do you have your teeth cleaned? _____

How often do you brush your teeth? _____ Floss? _____

Are your teeth sensitive to: Hot **(Y/N)** Cold **(Y/N)** Sweets **(Y/N)** Pressure **(Y/N)**

How long have you been a patient of your present dentist? _____

YES NO Have you ever received treatment for gum (periodontal) disease (scaling/root planing, gum surgery, gum grafting, etc.)? Date: _____

YES NO Do you clench or grind your teeth while sleeping or during the day?

YES NO Do you have popping, clicking or soreness in the jaw joints (TMJ)?

YES NO Have you ever had braces to straighten your teeth? Date: _____

YES NO Do you wear dentures or partials?

YES NO If so, are you pleased with their fit?

YES NO Have you had any teeth extracted in the past two years?
If so, for what reason?_____

I attest that, to the best of my knowledge, the information provided above is accurate and complete. Any changes in health status or medications will be reported to the Doctor at the next dental visit following the change. In addition, I authorize the Doctor or his representative to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis and to develop proper treatment recommendations.

Consent for treatment: _____ **Date** _____

INSURANCE INFORMATION

Dental:

Insurance _____ Phone # _____

Address _____

Insured's Name _____DOB _____SS#_____

Group # _____ ID # _____

I authorize Pine Belt Periodontics, PLLC, to verify benefits, file claims and receive payment from my insurance company.

Signature _____ Date _____

Medical :

Insurance _____ Phone # _____

Address _____

Insured's Name _____DOB _____SS#_____

Group # _____ ID # _____

I authorize Pine Belt Periodontics, PLLC, to verify benefits, file claims and receive payment from my insurance company.

Signature _____ Date _____

PINE BELT PERIODONTICS, PLLC

Today's Date: _____ Have you/anyone in your family seen us before _____

Patient Name _____ Date of Birth _____ Age _____

Address _____

City _____ State _____ Zip Code _____

Home Phone: _____ Cell: _____ Work: _____

E-mail address _____

SS# _____

Occupation _____ Employed By _____

Can we invite you to like us on FaceBook? Y / N

_____Spouse _____Parent Name _____

Employer _____ Phone _____

SS# _____ Date of Birth _____

Whom may we thank for referring you _____

City_____

I give Pine Belt Periodontics permission to discuss my medical and dental information with the following people:

1) _____

2) _____

MEDICAL HISTORY

Are you currently under the care of a pain management doctor?_____

If so, whom_____ **Phone**_____

Are you currently taking: Blood Thinner _____ **Asprin**_____

Please list your current physician (s):

A) _____ Phone _____

B) _____ Phone _____

Circle any condition you now have or have had in the past:

Heart Disease or Attack	COPD	Liver Disease	Enlarged Glands or Lymph Nodes
Congestive Heart Failure	Emphysema	Pancreas Disease	Sickle Cell Disease
Angina Pectoris	Tuberculosis	Epilepsy or Seizures	Kidney Disease
Congenital Heart Defect	Asthma	Fainting or Dizzy Spells	Bladder Infection
Mitral Valve Prolapse	Allergies or Hives	Chronic Severe Headaches	Prostate Disease
Heart Surgery	Diabetes (Type I or II)	HIV	Gall Bladder Disease
Heart Pacemaker	Arthritis	AIDS	Unusual Bruising or Bleeding
Artificial Heart Valve	Rheumatism	Blood Transfusion	Anemia or Blood Disorders
Irregular Heart Beat (Arrhythmia)	Osteoporosis	Drug or Alcohol Addiction	Hemophilia
High Blood Pressure	Fibromyalgia	Glaucoma or Cataracts	Thyroid Disease
High Cholesterol	Systemic Lupus	Eye Disorders	Parathyroid Disease
Stroke	Steroid Therapy	Cancer or abnormal growth	Ulcers or Colitis
Shortness of Breath	Hepatitis (A, B, C, D, E)	Radiation Therapy	Gastric Reflux
Artificial Joint (Knee, Hip)	Hepatitis B Carrier	Chemotherapy	Neurological problems
			Anxiety, emotional, or stress-related therapy

Current Medications: _____

_____

_____

Are you allergic to or have you had an adverse reaction to:

Penicillin	Keflex	Tylenol	Versed	Local anesthetic	Other:
Erythromycin	Codeine	Valium	Iodine	Epinephrine	
Tetracycline	Aspirin	Demerol	Latex gloves	Sulfa Drugs	

Please list any major operations: _____

Height_____ **Weight**_____

YES NO Do you smoke? How much? _____ How long? _____
YES NO Are you on a special diet?
YES NO Do you have any disease, condition or problem not listed above?
YES NO Are you pregnant?
YES NO Are you presently breast feeding?
YES NO Are you taking birth control pills or hormonal supplements?

Patient Signature _____**Date**_____