Periodontal Clinic

Practice limited to Periodontics and Implant Surgery.

Mike Jee, DDS MS, Diplomat, American Board of Periodontology
Grace Ng, DDS

PATIENT INFORMATION

(Please complete both sides)

Date ______________

Name (Mr. Mrs. Ms. Dr.) ______________

Home address ______________

City ______________ State ______ Zip ______

Home/Cell phone ______________

email ______________

Birthdate ______________ Age ______

Soc. sec. # ______________

Spouse's name ______________

Birthdate ______________ Age ______

Social Security # ______________

Responsible party if patient is a minor ______________

College attending ______________

EMPLOYMENT

Occupation ______________

Employer name ______________

Work address ______________

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City ______________ State ______ Zip ______

Work phone ______________

email ______________

SPOUSE'S EMPLOYMENT

Occupation ______________

Employer name ______________

Work address ______________

City ______________ State ______ Zip ______

Phone number ______________

Insurance Information

If you have dental insurance, please complete the following and apprise us as any changes occur in your coverage.

PRIMARY DENTAL COVERAGE

Subscriber name ______________

Insurance company ______________

Insurance company address ______________

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Group or policy # ______________

Subscriber ID# ______________

SECONDARY DENTAL COVERAGE

Subscriber name ______________

Insurance company ______________

Insurance company address ______________

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Group or policy # ______________

Subscriber ID# ______________

ASSIGNMENT & RELEASE

I recognize that I am financially responsible for any services rendered to me at this office. As a special service to me, insurance claims may be prepared and submitted on my behalf. I hereby authorize this office to release any information to my insurance company that is needed for the filing of my claims.

Signature ______________ Date ______________

Dental History

Referred by ______________

Current dentist ______________ How long? ______

Previous dentist ______________ City ______

When was your last cleaning? ______________

How many cleanings per year? ______________

Have you had recent xrays? ______________

Dental History (Continued from front)

DO YOU HAVE OR HAVE YOU EVER HAD (Please circle)

Head or neck injuries	Yes / No	Trouble opening or closing mouth	Yes / No	Problems of the TMJ (jaw joint)	Yes / No
Sensitive teeth	Yes / No	Prolonged bleeding after extractions	Yes / No	Dissatisfaction with the appearance of your teeth	Yes / No
Grinding or clinching teeth	Yes / No	Orthodontic treatment (braces)	Yes / No		
Difficulty chewing	Yes / No	Periodontal disease (Pyorrhea)	Yes / No		

Medical History

Primary physician ______________________ How long? __________ Specialty ______________

Office address ______________________ Phone number ______________________

Secondary physician ______________________ How long? __________ Specialty ______________

Office address ______________________ Phone number ______________________

DO YOU HAVE OR HAVE YOU EVER HAD (Please circle)

1. Circle any medication you have had an adverse reaction to:

aspirin	penicillin
erythromycin	tetracycline
codeine	sedatives/sleeping pills
dental anesthetics	other medications (list)

2. Hospitalization for illness or surgery	Yes / No
3. Hepatitis	Yes / No
4. Jaundice (yellow skin and eyes)	Yes / No
5. Epilepsy	Yes / No
6. Arthritis	Yes / No
7. Venereal disease	Yes / No
8. Rheumatic fever	Yes / No
9. Scarlet Fever	Yes / No
10. Anemia or other blood disorder	Yes / No
11. Prolonged bleeding due to slight cut	Yes / No
12. Kidney disease	Yes / No
13. Diabetes	Yes / No
14. Stomach or duodenal ulcer	Yes / No
15. Liver disease	Yes / No
16. Tuberculosis	Yes / No
17. Emphysema	Yes / No
18. Thyroid or parathyroid disorder	Yes / No
19. Heart trouble	Yes / No
20. Heart murmur	Yes / No
21. Prosthetic heart valve	Yes / No
22. Prosthetic joint (hip or knee)	Yes / No
23. Arteriosclerosis	Yes / No
24. High blood pressure	Yes / No
25. Low blood pressure	Yes / No
26. Persistently swollen ankles	Yes / No
27. A stroke	Yes / No
28. Shortness of breath on mild exertion	Yes / No
29. Chest pain	Yes / No
30. Hives, skin rash, hay fever	Yes / No
31. Psychiatric treatment	Yes / No
32. A tumor or abnormal growth	Yes/ No
33. Radiation treatment by cobalt, radium, xray or any other source	Yes / No
34. Glaucoma	Yes / No
35. Contact lenses	Yes / No
36. Prostate disorders	Yes / No
37. Blood transfusions	Yes / No
38. Substance abuse (alcohol, drugs IV)	Yes / No
39. Immune deficiency syndrome (HIV, AIDS)	Yes / No
40. Asthma	Yes / No

ARE YOU

41. Presently being treated for illness	Yes / No
42. Taking any medications (please list)	Yes / No
43. Aware of any recent weight change	Yes / No
44. Often thirsty	Yes / No
45. Urinating more than six times a day	Yes / No
46. Often exhausted or fatigued	Yes / No
47. A smoker	Yes / No
48. Generally a nervous person	Yes / No
49. Often unhappy or depressed	Yes / No
50. Aware of health change in the past year	Yes / No

IF FEMALE, ARE YOU NOW

51. Pregnant	Yes / No
52. Taking birth control pills or hormones	Yes / No
53. Presently in menopause "change of life"	Yes / No
54. Past menopause	Yes / No

PLEASE EXPLAIN FULLY ANY "YES" ANSWERS ABOVE

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If there are any changes in my medical condition or history I will notify the dentist or your office.

Patient Signature ______________________ Date __________

Doctor Signature ______________________ Date __________

Reviewed by __________ Date __________

Reviewed by __________ Date __________

Reviewed by __________ Date __________