Connie A. Lee, D.D.S., M.S.
Roger G. Ettel, D.D.S., M.S.
Diplomates American Board of Periodontology

Practice Limited to Periodontics
Including Implants

4801 Hwy. 61, Suite 300
White Bear Lake, MN 55110
Phone (651) 429-2299
Fax (651) 429-6630
mnperioassociates.com

Patient History Record

This personal information will help us provide quality care by taking into consideration your individual needs. It is important to have complete answers. All information is, of course, confidential.

Name (first, middle, last) ______________________ S.S. No. ______________

Date of Birth ______________ Parent's Name if Minor ______________________

Home Address ______________________ City ______________ State ____ Zip ________

Home Phone (____) ____________ Business Phone (____) ____________ Cell Phone (____) ____________

Employer ______________________ Primary Dental Insurance Co. Name ______________________

Insurance Company Address ______________________ Group # ______________

______________________ Phone # ______________

Insured's Name ______________________ Insured's Employer ______________

Insured's ID # ______________________ Insured's DOB ______________

Secondary Dental Ins. Co. Name ______________________________

Ins. Co. Address ______________________ Group # ______________

______________________ Phone # ______________

Insured's Name ______________________ Insured's Employer ______________

Insured's ID # ______________________ Insured's DOB ______________

Whom may we thank for referring you? ______________________________

Physician's Name ______________________ Phone # ______________

Emergency Contact Name ______________________ Phone # ______________

Health History

		YES	NO
1.	Are you experiencing pain from your mouth at this time or lately?	❍	❍
2.	Have you had previous periodontal (gum) treatments?	❍	❍
3.	How often do you have your teeth cleaned? ______________________ When was the last time? ______________________		
4.	Do your gums ever bleed?	❍	❍
5.	Do you have sores, swelling, or blisters on your gums, cheeks or lips?	❍	❍
6.	Have you noticed any loose or shifting teeth?	❍	❍
7.	Are your teeth sensitive to heat, cold or sweets?	❍	❍
8.	Does food wedge between your teeth?	❍	❍
9.	Have you had your teeth straightened?	❍	❍
10.	Do you have difficulty chewing?	❍	❍
11.	Are you aware of grinding or holding your teeth tightly together?	❍	❍
12.	Do you have clicking or pain in your jaw joints?	❍	❍
13.	Do you have headaches regularly?	❍	❍
14.	Would you be tremendously disturbed if you had to lose your teeth?	❍	❍
15.	Did either your mother, father, brother or sister lose all their natural teeth?	❍	❍

(see other side)

	YES	NO
16. Have you ever had an extremely frightening experience with dentistry?	❍	❍
17. Do you tend to worry or fret much of the time?	❍	❍
18. Do you smoke?	❍	❍
If so, how much? ______		
19. Do you engage in regular exercise?	❍	❍
If so, describe briefly ______		

20. Do you consider your medical health to be: ❍ Good ❍ Fair ❍ Poor

	YES	NO
21. Have you had any serious illness or operations?	❍	❍
If so, please explain ______		
22. Are you being treated by a doctor at this time?	❍	❍
If so, for what? ______		
23. Are you taking any medicines, drugs or pills regularly? (including over-the-counter medications)	❍	❍
If so, what? ______		
24. Have you ever taken any cortisone?	❍	❍
If so, when and for how long? ______		
25. Is there a history of diabetes in your family?	❍	❍

26. When was your last medical check-up? ______

27. Have you ever had the following?

	YES	NO		YES	NO
Heart disease	❍	❍	Cancer	❍	❍
Heart murmur	❍	❍	Stomach ulcers or colitis	❍	❍
Rheumatic fever	❍	❍	Kidney disease	❍	❍
Pacemaker implanted	❍	❍	Liver disease	❍	❍
Artificial heart valves implanted	❍	❍	Gland disease	❍	❍
High blood pressure	❍	❍	Diabetes	❍	❍
Low blood pressure	❍	❍	Seasonal allergies	❍	❍
Anemia, blood disease	❍	❍	Fainting spells or seizures	❍	❍
Stroke	❍	❍	Alcohol or drug dependency	❍	❍
Bleeding problems	❍	❍	Psychiatric treatment	❍	❍
Hepatitis, jaundice, liver disease	❍	❍	Radiation treatments or chemotherapy	❍	❍
HIV infection or AIDS	❍	❍	Artificial joints (prosthesis)	❍	❍
Arthritis	❍	❍	Respiratory disease, asthma, T.B.	❍	❍
Skin disease	❍	❍	Glaucoma	❍	❍

28. Have you ever been allergic or reacted adversely to any of the following:

Aspirin	❍	❍	Penicillin or other antibiotics	❍	❍
Codeine	❍	❍	Others: ______	❍	❍
Novocaine	❍	❍	______	❍	❍
Latex	❍	❍			

29. (Women) Are you pregnant?	❍	❍
Are you taking oral contraceptives?	❍	❍
30. Are you on a diet at this time?	❍	❍

31. Do you have any disease, conditions or problems not listed above that you think I should know about? ______

______

I UNDERSTAND MY RESPONSIBILITY REGARDING THE FEES. If treatment is performed, I agree to pay the balance that is not paid by insurance with one of the payment options available to me.

Signature ______ **Date** ______

Comments ______