MINNESOTA Periodontal ASSOCIATES

The foundation for a great smile

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Diplomate American Board of Periodontology

Practice Limited to Periodontics
Including Implants

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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 (____) _____

Primary Email Address _____

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.	Did either your mother, father, brother or sister lose all their natural teeth?	❍	❍

(see other side)

	YES	NO
15. Have you ever had an extremely frightening experience with dentistry?	❍	❍
16. Do you smoke?	❍	❍
If so, how much? _____		
17. Do you engage in regular exercise?	❍	❍
If so, describe briefly _____		
18. Do you consider your medical health to be: ❍ Good ❍ Fair ❍ Poor		
19. Have you had any serious illness or operations?	❍	❍
If so, please explain _____		
20. Are you being treated by a doctor at this time?	❍	❍
If so, for what? _____		
21. Are you taking any medicines, drugs or pills regularly? (including over-the-counter medications)	❍	❍
If so, what? _____		
22. Have you ever taken any cortisone?	❍	❍
If so, when and for how long? _____		
23. Is there a history of diabetes in your family?	❍	❍
24. When was your last medical check-up? _____		

25. 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	❍	❍

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

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

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

29. 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 _____