ADVANCED
PERIODONTICS & IMPLANTS

## REGISTRATION

Name _____ Date_____

Sex: M F Weight _____ Height _____ Date of Birth _____ Age_____

Marital Status _____ Spouse's Name _____

Social Security # _____ Email Address:_____

Residence Address _____
Street City State Zip

Telephone _____ (Home) _____(Cell)

Preferred Contact Method: ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Text Message ☐ Email

Employed by _____

Position _____

Business Address _____

Business Telephone _____

Name of Family Dentist _____

How long have you been under his/her care? _____

Name of Physician (Medical Doctor)_____

Address of Physician_____
Street City State Zip

Physician's (Medical Doctor) Telephone (If Known) _____

Who may we thank for referring you to our office? _____

Why were you referred to Advanced Periodontics and Implants? _____

Do you have any dental benefits (Insurance)? ☐ Yes ☐ No If yes, we would like a copy of the policy card.

Name and Address of Carrier _____

Group Number _____Subscriber ID Number _____

Person Responsible for This Account _____Policy Holders Birthdate_____

Person to Notify in Case of Emergency _____(Name)_____(Phone)

Pharmacy of preference for prescriptions _____

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MEDICAL AND DENTAL HISTORY
GENERAL HEALTH
THE FOLLOWING INFORMATION IS CONFIDENTIAL AND FOR OUR RECORDS ONLY.

Circle One

..... What is your estimation of your general health? ☐Good ☐Fair ☐ Poor

Yes No Are you now under the regular care of a physician?
If so, for what? _____
When was your last physical examination?_____

Yes No Have you had any major operations, hospitalization or illnesses?
If so, for what? _____

Yes No Are you taking any pills, medication or drugs (prescribed, over the counter, herbal)? (please list)

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

**Yes No Has your physician ever told you to take antibiotics before dental appointments?**

Yes No Have you had an unusual or allergic reaction to any medicine or food? (please check all that apply)

_____ Penicillin (Amoxicillin)
_____Sulfa drugs
_____ Codeine
_____ Aspirin
_____ NSAIDS (ibuprofen or Aleve)
_____ Bisphosphonates
_____Sleeping pills (Benzodiazepines)
_____Tetracycline
_____ Dental anesthetic (Novocaine)
_____ Nitrous Oxide (Laughing Gas)
_____ Latex
_____Other:_____

Yes No Do you smoke? If so, how much? _____/day

Yes No Do you drink alcohol? If so, how much? _____/day

Yes No Are you on a diet of any kind? (please describe): _____

Yes No Has any member or your family had diabetes, heart disease, or cancer?
If yes, who? _____

..... Do you have or have you ever had: (please check all that apply)

_____Rheumatic fever
_____Heart murmur
_____Atrial Fibrillation
_____Heart attack
_____Arteriosclerosis
_____High or low blood pressure
_____Shortness of breath or chest pain upon exertion
_____Stroke
_____
_____Swelling of the hands, feet or eyes
_____Dizziness or light headedness
_____Diabetes
_____Abnormal thirst
_____Painful or frequent urination
_____Slow, poor or incomplete healing
_____Anemia or other blood disorder
_____Frequent headaches
_____Rashes or skin disorders
_____Glaucoma
_____Frequent fractures or dislocations
_____Hepatitis, jaundice or other liver disease
_____Osteoporosis
_____Ulcers (stomach)
_____Kidney or bladder trouble
_____Thyroid or parathyroid disease
_____Condition requiring steroid use (cortisone)
_____Artificial joint(s)
_____Arthritis or rheumatism
_____Asthma or difficulty breathing
_____Tuberculosis
_____Frequent vomiting or diarrhea
_____Epilepsy, seizures, convulsions or fainting spells
_____Tumors or growths
_____Treated for cancer (if so, list details)
Type _____
Diagnosed_____
Treatments:
☐ Chemotherapy
☐ Radiation
☐ Surgery

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## GENERAL HEALTH (continued)

Circle One

Yes No Are you excessively nervous or depressed?
Yes No Have you ever been treated for nervous or mental disorders?
Yes No Have you ever experienced or been treated for chemical dependencies?
Yes No Have you recently gained or lost excessive amounts of weight?
Yes No Have you had abnormal bleeding after a cut or a tooth extraction?

### WOMEN ONLY:

Yes No Are you currently pregnant or breast feeding?
Yes No Are you taking birth control pills?

### DENTAL HEALTH

Yes No Do you consider yourself in good dental health?
Yes No Do you think that your teeth are affecting your health in any way?
Yes No Are you dissatisfied with the appearance of your teeth?
Yes No Are you dissatisfied with your chewing ability?
..... Have you ever had:

_____Orthodontic treatment (Braces) _____Your teeth ground or bite adjusted
_____Oral Surgery (Extraction, etc.) _____A nightguard or bite appliance
_____Periodontal treatment _____Dental implant treatment

Yes No Have you noticed any loosening of your teeth?
Yes No Does food tend to become caught between your teeth?
Yes No Do you suffer from pain and/or swelling of your gums?
Yes No Do your gums often bleed when you brush or floss your teeth?
Yes No Do you have any unpleasant odor or taste in your mouth?
Yes No Are you missing any teeth?

Why?: Decay ( ) Gum Disease ( ) Abscess ( ) Other ( )_____

Yes No Have missing teeth been replaced? With what?_____
Yes No Have you ever had any soreness, pain, clicking or popping in the area in front of your ears?
..... Do you: _____Clench or grind your teeth while awake or asleep

_____Bite your lips or cheeks regularly?
_____Hold foreign objects with your teeth?
_____Breathe primarily through your mouth?

When did you last have your teeth cleaned before this appointment? _____
How long before that? _____
How often do you see your dentist / hygienist? _____
How often and when do you brush your teeth? _____
Do you use: Hand toothbrush ( ) Electric toothbrush ( )
Is your toothbrush: Soft ( ) Medium ( ) Hard ( )
What else do you use to clean your teeth? (floss, toothpick, Waterpik®, etc.) _____
How often? _____
Yes No Do you feel apprehensive when you are having dental treatment?
Yes No Would you be interested in being sedated or using nitrous oxide (laughing gas) for treatment?
Yes No Is it important to you to keep your teeth?
Yes No Would you spend fifteen minutes a day in order to keep your natural teeth?

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health/dental history and that Dr. Recker and his staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold Dr. Recker, or any other member of his staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form. If necessary, I authorize the release of my health/dental records from my physician/dentist to Advanced Periodontics and Implants.

Signature of Patient/Legal Guardian_____ Date_____