

# Welcome

Please complete this form so that we can provide the best care possible for you.

**About you:** Name: \_\_\_\_\_ Nickname: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Marital Status:  Single  Married  Spouse's Name: \_\_\_\_\_

Divorced  Widowed

Preferred Method of Payment  Cash  Check  Credit card

Name of Parent or Guardian (if minor) \_\_\_\_\_

**Telephone Information:** Home \_\_\_\_\_

Work \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email address: \_\_\_\_\_

When is the best time to call you? after \_\_\_ am or after \_\_\_ pm Best # to call: \_\_\_\_\_

In case of emergency, who should we call? Name/Phone# \_\_\_\_\_

**Dental Insurance Info:** Carrier Name: \_\_\_\_\_

Address/ Phone # of Insurance Co. \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Relationship: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Group/ ID Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Name of Employer: \_\_\_\_\_

**Secondary Ins. Carrier Name:** \_\_\_\_\_

Address/Phone# of Insurance Co. \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Relationship: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Group/ ID Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Name of Employer: \_\_\_\_\_

## Dental History:

Why have you come to see the Periodontist today? \_\_\_\_\_

How would you describe the condition of your teeth and gums?  Good  Fair  Poor

Are you currently in pain or discomfort with your teeth or gums?  Yes  No If yes, please explain? \_\_\_\_\_

Date of your last complete exam/cleaning? \_\_\_\_\_ Referring dentist name? \_\_\_\_\_

Are you satisfied with the way your teeth look?  YES  NO If you could change anything about your smile what would you like to do? \_\_\_\_\_

How often do you brush your teeth? \_\_\_\_\_ Do you regularly floss you teeth? \_\_\_\_\_

Do your gums bleed when you brush / floss? \_\_\_\_\_

Do you experience any sensitivity to Hot or Cold? \_\_\_\_\_ Biting or Chewing? \_\_\_\_\_

Have you ever noticed any mouth odors or bad tastes? \_\_\_\_\_

Do you clench or grind your teeth? \_\_\_\_\_ Have tired jaws, especially in the morning? \_\_\_\_\_

Have you ever had:

Periodontal Treatment? \_\_\_\_\_

Orthodontic Treatment? \_\_\_\_\_

Serious Injury to Head/ Mouth? \_\_\_\_\_

**Medical History:** Physician \_\_\_\_\_ Phone Number: \_\_\_\_\_

Last visit: \_\_\_\_\_ Current health:  Excellent  Good  Fair  Poor

Do you smoke or chew tobacco?  NO  YES: How much per day? \_\_\_\_\_

Are you currently taking any prescription or non-prescription medications:  YES  NO

If yes, please list below. (You may attach a separate sheet if necessary).

Name of medication:

\_\_\_\_\_  
\_\_\_\_\_

Are you currently taking any aspirin-like products?

Have you had any serious medical problems within the past 5 years?  YES  NO, if yes,

Please explain \_\_\_\_\_

For Women: Are you pregnant?  YES  NO, If yes, how many months? \_\_\_\_\_

Are you taking birth control pills?  YES  NO

**Do you need to be pre-medicated before Dental Treatment?**  YES  NO  DON'T KNOW

If yes, what medication and dose do you take? \_\_\_\_\_

Are you aware of having an allergic or adverse reaction to any medication?  YES  NO

If yes please explain \_\_\_\_\_

**Please CIRCLE the appropriate response**

Have you ever had or been treated for any of the following diseases or medical problems?

- |  |  |
|--|--|
| Y N Heart Attack/Heart Surgery/ Stroke | Y N Heart Murmur/Rheumatic Fever         |
| Y N Mitral Valve Prolapse              | Y N Artificial Joint Replacement         |
| Y N Pacemaker                          | Y N High/Low Blood Pressure              |
| Y N Hepatitis/Jaundice/Liver Disease   | Y N Abnormal Bleeding                    |
| Y N Cancer/Chemotherapy/Radiation      | Y N Kidney Problems                      |
| Y N Thyroid Problems                   | Y N Glaucoma                             |
| Y N Diabetes                           | Y N Emphysema                            |
| Y N HIV/AIDS                           | Y N Tuberculosis                         |
| Y N Asthma/Allergies                   | Y N Latex Sensitivity                    |
| Y N Psychiatric Care                   | Y N Drug/Alcohol Abuse                   |
| Y N Anemia                             | Y N Epilepsy/Seizures/Fainting/Dizziness |

Have you been treated for any other illness not listed above?  YES  NO If yes, please explain: \_\_\_\_\_

I grant authority to Drs Trylovich, Gifford & Goaslind, D.D.S. and their practice auxiliaries to perform dental and surgical procedures and treatment, including the administration of medicines and local anesthetics that are deemed necessary and advisable. Patient and /or legal guardian/parent will be informed before treatment is performed.

I authorize the practice of Drs Trylovich, Gifford & Goaslind, D.D.S. to release any information necessary to expedite insurance claims. I understand that I am ultimately responsible for ANY and ALL charges regardless of insurance coverage.

I consent to the taking of photographs and videos before, during, and after treatment, and to the use of same by the doctor in scientific papers or demonstrations. Consent \_\_\_\_\_ Do Not Consent \_\_\_\_\_

I hereby certify this information to be true and correct to the best of my knowledge.

\_\_\_\_\_  
Signature of patient (parent or Guardian if minor)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Update Signature/ Date

\_\_\_\_\_  
Update Signature/ Date