W. Peter Nordland, D.M.D., Inc.

FOR OFFICE USE ONLY

PATIENT INFORMATION

Date _____ Date of Birth _____

Patient _____ Home Phone _____

Home Address _____ Work Phone _____

City _____ State _____ Zip _____ Cell Phone _____

Patient's Occupation _____ Soc. Sec. No. _____

Patient's Employer _____ Address _____ Phone _____

Spouse's Name _____ Spouse's Occupation _____

Spouse's Employer _____ Address _____ Phone _____

Spouse's Soc. Sec. No. _____

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

In case of emergency, please give us the name, address and phone number of a close relative not living with you _____

_____

INSURANCE

If you would like our office to bill your insurance for you, please provide us with a dental insurance card or insurance form,

PRIMARY INSURANCE COMPANY _____ SECONDARY INSURANCE COMPANY _____

To avoid misunderstandings regarding dental insurance, we wish that our patients know that ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED DIRECTLY TO THE PATIENT and that PATIENTS ARE PERSONALLY RESPONSIBLE FOR PAYMENT OF FEES. We will prepare lhe necessary forms or reports to help you obtain your benefits from insurance companies. We do not render our services on the basis that insurance companies will pay our fees.

MEDICAL HEALTH HISTORY

Periodontal disease is caused by a combination of complex factors and successful treatment depends upon their identification. The following questions are pertinent to the treatment of your periodontal condition. Please answer all questions. Circle yes or no, whichever applies. All answers are confidential. **If you have a heart murmur, you must be pre-medicated for all treatment, including the periodontal examination.**

1. How is your general health? _____
2. Date of last physical examination _____
3. Physician's name _____

Circle Yes or No

4. Are you being treated by a ☐ physician, or a ☐ psychiatrist now? ..... NO
5. Have you ever been ☐ seriously ill, or ☐ hospitalized? ..... NO

if so explain _____

_____

6. Are you taking any drugs or medication? If yes, please check the appropriate box ..... NO

- ☐ antibiotics
- ☐ insulin
- ☐ hormones
- ☐ aspirin (Please note: Chronic aspirin consumption can cause bleeding problems.)
- ☐ anticoagulants (blood thinners)
- ☐ blood pressure medicine
- ☐ heart medicine
- ☐ birth control pills
- ☐ tranquilizers
- ☐ cortisone (steroids)
- ☐ calcium sparing medications like N/A
- ☐ other _____

7. Have you ever had a serious infectious disease? ..... NO

☐ Hepatitis ☐ Tuberculosis ☐ Syphilis ☐ HIV ☐ Other _____

8. Do you have or have you had any of the following? ..... NO

- ☐ rheumatic heart condition
- ☐ heart palpitations
- ☐ high blood pressure
- ☐ a heart murmur
- ☐ heart attack
- ☐ chest pains on exertion
- ☐ low blood pressure
- ☐ shortness of breath
- ☐ heart trouble
- ☐ Other _____
- ☐ frequent headaches
- ☐ fainting or dizziness
- ☐ tension
- ☐ liver disorder
- ☐ kidney disorder
- ☐ lung problems
- ☐ X-ray therapy
- ☐ periods of depression
- ☐ cough
- ☐ cancer or tumor
- ☐ diabetes
- ☐ jaundice
- ☐ epilepsy
- ☐ ulcer
- ☐ stroke
- ☐ arthritis
- ☐ anemia
- ☐ glaucoma
- ☐ use of Phen - Fen or other appetite suppressants
- ☐ brittle bone disease

PLEASE COMPLETE REVERSE SIDE

9. Have you had abnormal bleeding associated with extractions, surgery, or menstruation? ..... NO

10. Do you have any implants such as a heart valve or hip replacement? ..... NO

Please explain: _____

What type of antibiotic premedication do you take prior to dental visits? _____

11. Are you allergic or have you experienced an unusual reaction to any drugs? ..... NO

- ☐ dental anesthetic
- ☐ codeine
- ☐ aspirin
- ☐ erythromycin
- ☐ penicillin
- ☐ sulfa drugs
- ☐ tetracycline
- ☐ other antibiotics
- ☐ barbituates or sedatives
- ☐ other _____

12. Do you have any allergic condition? ..... NO

- ☐ asthma
- ☐ skin rashes, hives, hayfever
- ☐ sinus problems

13. Do you smoke? ..... NO

14. Do you drink alcoholic beverages? ..... NO

15. Have you ever had an alcohol or drug related problem? ..... NO

16. Is there a tendency towards any illness in your family? ..... NO

- ☐ diabetes
- ☐ heart trouble
- ☐ other _____

17. Do you have any disease, condition, or problem not listed that I should know about? ..... NO

_____

18. Women: Are you pregnant? ..... NO

DENTAL HEALTH HISTORY

Circle Yes or No

1. Who is your regular dentist? _____

2. Has your dental care been:
   ☐ Regular (yearly) ☐ Intermittent (when necessary) ☐ Infrequent (when in pain) Approx. date of last visit _____

3. Have you ever had Periodontal care?... NO When? _____ Orthodontic care?.. NO When? _____

4. Would you be very disturbed if you had to lose your teeth and wear false teeth? ..... NO

5. Are you dissatisfied with the appearance of your teeth? ..... NO

6. Have you ever experienced any of the following? ..... NO

- ☐ bleeding gums
- ☐ swelling of gums
- ☐ pain or soreness in gums
- ☐ receding gums
- ☐ pus around the teeth
- ☐ loose teeth
- ☐ spaces between teeth
- ☐ drifting of teeth
- ☐ foul odor
- ☐ bad breath or bad taste
- ☐ food packing between teeth
- ☐ high or rough fillings

7. Is there sensitivity in your teeth? ..... NO

- ☐ hot
- ☐ cold
- ☐ sweet
- ☐ biting
- ☐ tooth brushing
- ☐ pressure

8. Have you ever had an injury to your face, neck, or jaws? ..... NO

9. Do you suffer from pain in the face, neck, or jaws? ..... NO

10 Did you ever have a bad experience in a dental office? ..... NO

11 Is there anything that concerns you about dental treatment? ..... NO

Remarks: _____

_____

_____

These statements are true and complete to the best of my knowledge.

_____ _____

Signature of Patient, Parent or Guardian — Date

Please be advised that a 24 hour notice of inability to keep your appointment is expected, otherwise a reasonable fee for time lost may be charged. In addition, we advise all patients to visit a general dentist for a decay examination annually.