Chart#:

## Patient Information

Patient Name: _____ Date:_____
Last, First MI (Preferred Name)

Gender: _____ Marital Status: _____ Social Security #:_____ Birth Date: _____

Drivers License #: _____ E-mail: _____

Phone (Home): _____ (Work): _____ Ext: _____ (Cell): _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code

Whom may we thank for referring you to our practice: _____

Pharmacy: _____ Hobbies/Interests: _____
Name Location Phone #

Family Physician: _____
Name Phone #

Other Specialists (ie, Internist, Cardiologist, Orthopedic, Please list all): _____

_____

General Dentist: _____ Date Last Seen: _____

Other Dental Specialist (ie, Endodontist, Periodontist, Please list all): _____

_____

**Why are you seeking evaluation & treatment at this time?** _____

_____

_____

## MEDICAL HEALTH INFORMATION

Please give the date of your last physical exam?_____

☐YES ☐NO Is your general health good?

☐YES ☐NO Do you usually pre-medicate with an antibiotic before dental treatment?
*If so, what medication & dosage*:_____

☐YES ☐NO Do you have any allergies or have you had any bad reactions to any medications, foods or metals?
Please list:_____

_____

☐YES ☐NO Do you smoke cigarettes? *How many packs per day?* _____

☐YES ☐NO Do you smoke cigars or a pipe? *How often?* _____

☐YES ☐NO Do you use any smokeless tobacco? How often & *What type?* _____

☐YES ☐NO Do you drink alcoholic beverages? *How often?* _____

☐YES ☐NO Do you take any **over the counter** medications? (*Give name and dosage*)

_____

☐YES ☐NO Do you take any **prescription** medications?(*Give name and dosage*)

_____

_____

Patient Name_____ Date_____

**Do you have or have you ever had any of the following?**

□YES □NO High blood pressure
□YES □NO Heart trouble (Type)_____
□YES □NO Heart by-pass (Date)_____
□YES □NO Chest pains
□YES □NO Heart Stint(s) (Date)_____
□YES □NO Heart arrhythmia
□YES □NO Artificial heart valve (Date)_____
□YES □NO Rheumatic fever
□YES □NO Heart murmur
□YES □NO Mitral valve prolapse
□YES □NO Dizziness or vertigo
□YES □NO Epilepsy
□YES □NO Diabetes: Well controlled Y / N
□YES □NO Females: Planning a pregnancy

□YES □NO Lung problem
□YES □NO Mental illness (Type) _____
□YES □NO Glaucoma
□YES □NO Bleeding problems
□YES □NO Tendency to bruise easily
□YES □NO Asthma
□YES □NO Artificial joints
□YES □NO Cancer
□YES □NO Stroke (Date)_____
□YES □NO Pacemaker (Date placed)_____
□YES □NO Polycythemia
□YES □NO Auto immune disease
□YES □NO Females: Are you pregnant
□YES □NO Females: Are you breastfeeding your baby

□YES □NO Do you take any type of blood thinner (including baby aspirin)? _____
□YES □NO Have you ever had a bad reaction during or after being sedated?

If you answered yes to any of the above, please provide additional information that you feel is important. If you have a condition, syndrome, disease or medical problem that is not mentioned above please list and describe . _____

_____

_____

## HEAD & NECK SYMPTOMS

□YES □NO Headaches from Forehead
□YES □NO Headaches from Temples
□YES □NO Cluster Headaches
□YES □NO Migraine
□YES □NO Jaw Pain
□YES □NO Pain in Cheek Muscles
□YES □NO Jaw Locking Open
□YES □NO Neck Stiffness
□YES □NO Neck Pain
□YES □NO Unwanted Facial Wrinkles

□YES □NO Headaches from Back of Head
□YES □NO Headaches from Under the Eyes
□YES □NO Maxillary Sinus Pain
□YES □NO Migraine with Aura
□YES □NO Limited Jaw Opening
□YES □NO Inability to Open Smoothly
□YES □NO Jaw Locking Closed
□YES □NO Shoulder Aches
□YES □NO Arm & Finger Tingling, Numbness, Pain
□YES □NO Unwanted Age Related Facial Changes

□YES □NO Would you like to be evaluated and given specific treatment options for any of these symptoms?

Is there any additional information that can help us better understand your symptoms? _____

_____

_____

Patient Name_____ Date _____

## ORAL HEALTH INFORMATION

**Please answer the following and provide an explanation if needed:**

□YES □NO Do you want to improve the appearance of your teeth?
□YES □NO Do you want to improve your ability to chew your food?
□YES □NO Do you want to improve your oral health?
□YES □NO Do you have any pain or soreness in your mouth?
□YES □NO Do you have any swelling in your mouth?
□YES □NO Have any of your teeth shifted?
□YES □NO Do your teeth mesh together well?
□YES □NO Have you noticed any gum recession?
□YES □NO Do your gums ever bleed?
□YES □NO Do you ever have a bad taste in your mouth?
□YES □NO Does your mouth ever feel uncomfortably dry?
□YES □NO Do you brush your teeth? (How often?) _____
*(What type of toothbrush? ie, soft, medium, hard, electric)*_____
□YES □NO Do you use toothpicks/proxybrushes? (How often?) _____
□YES □NO Do you floss your teeth? (How often?) _____
□YES □NO Do you use a water-pick or similar device?
If so, do you aim it so the liquid is forced under your gum line? □YES □NO
□YES □NO Are you *aware* of clenching, gritting or grinding your teeth while sleeping?
□YES □NO Are you *aware* of clenching, gritting or grinding your teeth while awake?
□YES □NO Do you wear a nightguard (what type?)_____
□YES □NO Do your jaws or jaw joints ever feel sore or painful?
□YES □NO Do your jaw joints ever pop or click?
□YES □NO Do you believe that your oral health is affecting your general health?
□YES □NO Have you noticed any changes in your facial appearance as a result of tooth loss?
□YES □NO Do you have any dental implants? (Location & date placed)_____
□YES □NO Do you believe you are about to lose your teeth?
□YES □NO Do you prefer to be sedated for most dental procedures?

How long would you like to keep your remaining teeth? _____
How often do you visit the Dentist for cleanings and preventative care?_____
When did you last have your teeth cleaned? _____
Please describe previous gum treatment including dates? _____
_____
Have you had any bad dental experiences we need to know about? _____
_____

Patient Name_____ Date _____

## Insured or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ (Cell) _____

Address: _____
Street Apartment #

_____
City State Zip Code

## Employment Information

The following is for the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City, State Zip Code Phone

## Dental Insurance Information

**Dental Primary**

Name of Insured: _____ Is insured a patient? ☐Yes ☐No
Last First MI

Insured's Birth Date: _____ ID #:_____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐Self ☐Spouse ☐Child ☐Other _____

Insurance Plan Name and Address: _____

_____

**Dental Secondary**

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #:_____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐Self ☐Spouse ☐Child ☐Other _____

Insurance Plan Name and Address: _____

_____

## Medical Insurance Information

Name of Insured: _____ Is insured a patient? ☐Yes ☐No
Last First MI

Insured's Birth Date: _____ ID #:_____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐Self ☐Spouse ☐Child ☐Other _____

Insurance Plan Name and Address: _____

Patient Name_____ Date _____

## CONSENT FOR EXAMINATION AND ACCEPTANCE OF FINANCIAL RESPONSIBILITY

I have read and answered all questions to the best of my knowledge. I agree to hold Clear Lake Periodontics, Dr. Robert Devoll and all members of the staff harmless for any adverse outcome due to errors or omissions that I have made in the completion of these form. I give my consent to any advisable and necessary procedures, medications or anesthetics to be administered by the attending dentist/periodontist or staff for diagnostic or treatment purposes.

I authorize the release of my medical/dental information from Clear Lake Periodontics/Dr. Robert Devoll to my dentist(s), insurance company, consulting dental specialist(s) and physician(s). I authorize the release of my medical/dental information from my dentist(s), insurance company and physician(s) to Clear Lake Periodontics/ Dr. Robert Devoll.

I permit payment directly to Clear Lake Periodontics/ Dr. Robert Devoll, any benefits due me for services rendered and as such hereby authorize assignment of my medical and dental benefits to Clear Lake Periodontics/ Dr. Robert Devoll. I agree to be financially responsible for services rendered and agree to immediately pay all amounts owed that are not covered by my insurance upon notice of non-coverage. I authorize the recording and publication of diagnostic and treatment photographs, videos, x-rays, and case history in dental publications, textbooks and continuing education presentations as long as my identity is protected in all cases.

_____

Patient Name *(Print)* Patient or Guardian Signature Date