BERKELEY PERIODONTICS & DENTAL IMPLANTS

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PATIENT INFORMATION

Today's Date _____

Name _____ Age _____ Date of Birth _____

Address _____ City _____ Zip _____

Telephone: Home (____) _____ Business (____) _____ Emergency (____) _____

Email _____

Employed by _____

Business Address _____ City _____ Zip _____

Occupation _____ Driver's License # _____ S.S. # _____

School/City (if a full time student over 18) _____

Name of Spouse, Partner, or Parent _____ Employed by _____

Business Address _____ City _____ Zip _____

Business Phone (____) _____ Occupation _____

IF YOU HAVE INSURANCE, PLEASE COMPLETE THE FOLLOWING:

PATIENT'S INSURANCE

Name of Insured _____

S.S. # _____ Birthdate _____

Employer _____

Insurance Co. _____

Address _____

_____

Telephone (____) _____

Policy or Group# _____

Union Local # _____

I authorize release of any information relating to this claim. I understand that I am responsible for all costs of dental treatment.

_____

Signed (patient or parent if minor) Date

SECONDARY INSURANCE

Name of Insured _____

S.S. # _____ Birthdate _____

Employer _____

Insurance Co. _____

Address _____

_____

Telephone (____) _____

Policy or Group# _____

Union Local # _____

I authorize release of any information relating to this claim. I understand that I am responsible for all costs of dental treatment.

_____

Signed (insured person) Date

DENTAL HISTORY

Your General Dentist _____ Telephone (____) _____ For How Long? _____

Referred by (if other than general dentist) _____

Present Problem _____

Last Cleaning (scaling, prophylaxis) _____ How often are your teeth cleaned? _____

Do your gums bleed? _____ When? _____

	YES	NO	Not Sure
Are your gums, teeth, or mouth sore?	❒	❒	❒
Do you get mouth infections or sores on your lips?	❒	❒	❒
Do you have a bad taste or odor in your mouth?	❒	❒	❒
Have you been told you have gum disease?	❒	❒	❒
Have your teeth become loose or drifted?	❒	❒	❒
Do you have gum boils or abscesses?	❒	❒	❒
Do you have discomfort with opening, biting or chewing?	❒	❒	❒
Does your jaw make popping or clicking noises?	❒	❒	❒
Do you clench or grind your teeth?	❒	❒	❒
Does the appearance of your mouth trouble you?	❒	❒	❒
Have you ever had complications with any dental treatment?	❒	❒	❒
Have you ever had injuries or trauma to jaw or teeth?	❒	❒	❒
Are your teeth sensitive to cold?	❒	❒	❒

Doctor Notes:

How many times per day do you brush your teeth? _____ ❒ Electric Toothbrush ❒ Manual Toothbrush

Check other items used: ❒ Floss ❒ Toothpicks ❒ Water Irrigator ❒ Proxabrush ❒ Other

What concerns do you have about dental treatment that you would like us to know? _____

OVER

MEDICAL HISTORY

Name of Physician _____ Telephone (____) _____ City _____ Specialty _____
Name of Physician _____ Telephone (____) _____ City _____ Specialty _____
If member of group health plan (such as Kaiser), your member number _____
How would you rate your health (please circle): Excellent Good Fair Poor

	YES	NO	Not Sure
Have you been under the care of a physician in the past 2 years?	❒	❒	❒
If so, for what problem? _____			
Date of last medical exam _____ . Any significant findings?	❒	❒	❒
Have you been hospitalized in the past 5 years?	❒	❒	❒
If so, for what problem? _____			
Have you had bleeding that was difficult to stop?	❒	❒	❒
Have you or any immediate family member had diabetes?	❒	❒	❒
Have you lost or gained more than 10lbs. in the past year?	❒	❒	❒
Have you had excessive thirst or dry mouth?	❒	❒	❒
Do you need to urinate frequently?	❒	❒	❒
Do you heal slowly or bruise easily?	❒	❒	❒

WOMEN ONLY	**YES**	**NO**	**Not Sure**
Are you pregnant?	❒	❒	❒
If yes, what month of pregnancy? _____			
Are you planning to become pregnant soon?	❒	❒	❒
Have you undergone, or are you undergoing menopause?	❒	❒	❒
If so, do you have any symptoms? _____	❒	❒	❒
Are you taking hormone pills or shots (including birth control)?	❒	❒	❒

I. IN THE LAST 12 MONTHS HAVE YOU TAKEN DRUGS, PILLS OR MEDICINES FOR:

YES	NO	
❒	❒	Diabetes (pills or 'shot')
❒	❒	Nerves (tranquilizers)
❒	❒	Sleeping
❒	❒	Heart problems
❒	❒	High blood pressure
❒	❒	Blood (liver or iron pills, etc.)
❒	❒	Stomach trouble (ulcer or other)
❒	❒	Headaches
❒	❒	Arthritis or rheumatism
❒	❒	Allergy
❒	❒	Thyroid

II. HAVE YOU EVER TAKEN:

YES	NO	
❒	❒	Dilantin
❒	❒	Bisphosphonates (Aredia, Fosamax, Bondronat, Actonel, Zometa, Boniva, etc.)

III. ARE YOU CURRENTLY TAKING:

YES	NO	
❒	❒	Aspirin or blood thinners

IV. DO YOU SMOKE TOBACCO?

YES NO
❒ ❒ If yes, how much? _____

V. HAVE YOU EVER HAD ANY OF THE FOLLOWING:

YES	NO	
❒	❒	Heart disease or heart surgery
❒	❒	Pacemaker or artificial heart valve
❒	❒	Mitral valve prolapse or heart valve surgery
❒	❒	Heart murmur
❒	❒	Stroke
❒	❒	Rheumatic fever or scarlet fever
❒	❒	Artificial joint or implant
❒	❒	High blood pressure
❒	❒	Fainting, convulsions, epilepsy
❒	❒	Frequent or severe headaches
❒	❒	Kidney disease
❒	❒	Lung or breathing disease (TB, asthma, emphysema)
❒	❒	Hepatitis, liver disease, jaundice
❒	❒	Arthritis, sore joints
❒	❒	Organ transplant
❒	❒	Tumor, cancer or chemotherapy
❒	❒	Blood disorder (anemia, leukemia, sickle cell)
❒	❒	Radiation or cobalt treatments
❒	❒	Alcohol or drug problem
❒	❒	Positive HIV virus
❒	❒	Psychiatric treatment

VI. HAVE YOU BECOME SICK FROM, SHOWN AN ALLERGY TO, OR BEEN TOLD NOT TO TAKE:

YES	NO	
❒	❒	Penicillin
❒	❒	Other antibiotics _____
❒	❒	Codeine or other pain relievers
❒	❒	Novocaine, Xylocaine or other dental anesthetics
❒	❒	Aspirin
❒	❒	Latex
❒	❒	Other

VII. LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Please explain any disease or problem not listed about that I should know about _____

_____

I have answered this information form as completely as possible.

_____ _____
Signature **Date**