STEPHEN R. JOHN, DDS, APC *Periodontics, Dental Implants and Laser Therapy*

PERSONAL RECORD

PLEASE PRINT CLEARLY AND FILL OUT COMPLETELY

Responsible Party_____
(Last) (First) (Middle)

Patient Name_____
(Last) (First) (Middle)

Social Security Number_____ Driver's license state & number_____

Street Address_____
(Address/Street) (City) (Zip Code)

Billing Address (if different)_____

Phone (Home)_____ Phone (Cell)_____ Phone (Work)_____

Sex_____ Marital Status_____ Birthdate_____ Physician_____

General Dentist_____ Referred by (if different)_____

Emergency Name & contact #_____

"I have received the Notice of Privacy Practices and have been provided an opportunity to review it"

Signature_____ **Date**_____

INSURANCE INFORMATION ***Your insurance cannot be processed unless all information is provided****

Insured by: Self/Parent [ ] Spouse/Partner [ ] Both [ ] *Fill out both sections

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PRIMARY INSURANCE (Self/Patient/Parent)

Name_____

Dental Insurance_____

Employer_____

Address_____

Group/Union #_____

Social security #_____

Birthdate_____

SECONDARY INSURANCE (Spouse/Partner)

Name_____

Dental Insurance_____

Employer_____

Address_____

Group/Union #_____

Social security #_____

Birthdate_____

"I authorize the holder of any pertinent dental information about me to release to my insurance company any information needed for this and any related claim and I authorize payment directly to the dentist of the group insurance benefits otherwise payable to me. I hereby permit this signature to be used in lieu of on the original insurance form."

Signature_____ **Date**_____

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MEDICAL HISTORY

Your general health is an important factor and may influence the course of periodontal disease. To aid in establishing a thorough diagnosis and treatment, please complete this history form.

Please Circle

1. Do you consider yourself to be in good health? **YES NO ?**

2. Do you need to take a premedication (antibiotic) prior to your dental appointment for :
   Heart Condition? **YES NO ?**
   Hip Replacement or Knee Replacement? **YES NO ?**
   Other_____ **YES NO ?**

3. Are you being treated by a physician now? **YES NO ?**
   If so, what for?_____

4. Have you been hospitalized or had surgery within the last two years? **YES NO ?**
   IF so, what for_____

5. Are you taking any medications? What are they? **YES NO ?**
   [ ] Antibiotic_____ [ ] Blood Pressure Medicine_____
   [ ] Aspirin_____ [ ] Anti-Coagulants_____
   [ ] Diabetic medicine_____ [ ] Birth Control pills_____
   [ ] Hormones_____ [ ] Steroids_____
   [ ] Bisphosphonate_____ [ ] Sedatives_____
   [ ] Other_____

6. Have you had any of the following conditions? **YES NO ?**

[ ] Heart Disease	[ ] High Blood Pressure	[ ] Valve Defect	[ ] Arterial Stent
[ ] Stroke	[ ] Blood Disease/anemia	[ ] Excessive Bleeding	[ ] Kidney Disorder
[ ] Hepatitis/Jaundice	[ ] Liver Disease	[ ] HIV Related Problems	[ ] Venereal Disease
[ ] Diabetes	[ ] Skin Disease	[ ] Arthritis/Joint Problems	[ ] Auto Immune Disease
[ ] Respiratory Disorder	[ ] Tuberculosis	[ ] Asthma/Hay Fever	[ ] Sinus Problems
[ ] Epilepsy	[ ] Emotional Problems	[ ] Emotional Stress	[ ] Glandular Disorder

   [ ] Other_____

7. Have you become sick, shown an allergy to, or been told not to take? **YES NO ?**
   [ ] Penicillin/Amoxicillin/Keflex [ ] Erythromycin [ ] Tetracycline [ ] Cleocin/Clindamycin
   [ ] Barbiturates/Sedatives [ ] Valium [ ] Codeine [ ] Vicodin
   [ ] Local Anesthetics (Novacaine) [ ] Latex [ ] Aspirin [ ] Other_____

8. Do you smoke? How much?_____ PPD_____ **YES NO ?**

9. Have you ever had Chemo or Radiation therapy for cancer? **YES NO ?**

10. Women: Are you pregnant? What Trimester?_____ **YES NO ?**

11. Do you have any other condition not listed?_____ **YES NO ?**
    What?_____

Signature_____ **Date**_____

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DENTAL HISTORY

1. Dental complaint at the moment_____

2. How long have you been aware of your periodontal problem?_____
3. Are you experiencing discomfort from your mouth at this time? **YES NO ?**
4. Have you had previous periodontal treatment?_____
   (When) (Where)
5. Do your gums ever bleed when you brush your teeth? **YES NO ?**
6. Are your gums receding? **YES NO ?**
7. Have you noticed any mouth odors or bad breath? **YES NO ?**
8. Do you suffer from pain and/or swelling of your gums? **YES NO ?**
9. Have you ever had a sore mouth, trenchmouth or pyorrhea? **YES NO ?**
10. Are any of your teeth sensitive to heat, cold, chewing and/or sweats? **YES NO ?**
11. Have you noticed any loosening of your teeth? **YES NO ?**
12. Have you noticed drifting/movement of your teeth? **YES NO ?**
13. Do you develop cold sores, canker sores, fever blisters or other sores? **YES NO ?**
14. Have you ever had your teeth straightened? **YES NO ?**
15. Do you often find yourself clenching and/or grinding your teeth? **YES NO ?**
16. Do you ever experience sounds in the joints of your jaw? **YES NO ?**
17. Do you suffer from pain or sensitivity of the joints of your jaw? **YES NO ?**
18. Have you ever been treated for pain in the jaw joint? **YES NO ?**
19. Have you ever had an occlusal adjustment or your teeth ground to improve your bite? **YES NO ?**
20. Have you ever had a bad reaction to a dental anesthetic? **YES NO ?**
21. Have you ever had a complication following dental surgery or treatment? **YES NO ?**
22. Do you have anxieties about dental procedures? **YES NO ?**
23. How often do you have your teeth cleaned by a dentist or hygienist?_____

24. When was your last professional cleaning?_____
25. Do you know what dental plaque/bacteria is? **YES NO ?**
26. How often do you brush your teeth?_____

27. What do you use to clean in between your teeth?_____
28. Do you use a mouthwash/rinse regularly? **YES NO ?**

Signature_____ **Date**_____

FINANCIAL POLICY

"I have been provided a complete copy of Dr. Stephen John's financial policy. I have read and understand the Financial Policy. All questions have been answered."

Signature_____ **Date**_____