Olde Naples Periodontics
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SPECIALIZING IN
PERIODONTICS & DENTAL IMPLANTS

NEW PATIENT INFORMATION

NAME_____DATE_____

LOCAL ADDRESS_____CITY_____ST_____ZIP _____

PHONE ( )_____CELL ( )_____

EMAIL _____

NORTHERN ADDRESS_____CITY_____ST_____ZIP _____

OCCUPATION AND EMPLOYER _____

BUSINESS ADDRESS_____CITY_____ST_____ZIP _____

BUSINESS PHONE ( )_____SOCIAL SECURITY #_____

AGE_____BIRTHDATE____/____/____ MARITAL STATUS_____

SPOUSE'S NAME _____

SPOUSE'S EMPLOYER _____SPOUSE'S S.S. # _____

D.O.B. (SPOUSE) _____

SPOUSE'S BUSINESS PHONE ( ) _____

NAME OF DENTIST_____ HOW LONG?_____

NAME OF PHYSICIAN _____ HOW LONG?_____

BY WHOM WERE YOU REFERRED?_____

DO YOU HAVE DENTAL INSURANCE? _____

Please answer the following questions by circling yes or no. Though some of the questions may seem unrelated to your gum condition, they are all essential in assessing your general health status and resistance, and therefore are important considerations in the diagnosis and treatment of periodontal disease.

DATE OF YOUR LAST DENTAL CLEANING _____

DATE OF YOUR LAST PHYSICAL EXAM _____

YES NO ARE YOU BEING TREATED FOR ANY MEDICAL PROBLEM?

If so, What? _____

YES NO HAVE YOU HAD ANY SERIOUS ILLNESS OR OPERATION?

If so, What and When? _____

YES NO HAVE YOU HAD EXCESSIVE BLEEDING REQUIRING SPECIAL TREATMENT?

YES NO ARE YOU ALLERGIC TO ANY DRUGS OR MEDICATIONS? Examples: Aspirin, Penicillin, other Antibiotics, Local Anesthetics, (Novocaine), Codeine, Barbiturates, Sleeping pills, Narcotics, Alcohol.

YES NO HAVE YOU BEEN TOLD TO AVOID ANY DRUGS OR MEDICATIONS?

YES NO DO YOU CONSUME ALCOHOL? If so, how many glasses daily?_____

YES NO DO YOU TAKE ANY RECREATIONAL DRUGS_____

OVER

HAVE YOU HAD ANY OF THE FOLLOWING CONDITIONS?

YES NO HEART CONDITION, HEART MURMUR, IMPLANT, HEART ATTACK, OR STROKE?
YES NO RHEUMATIC FEVER?
YES NO HIGH OR LOW BLOOD PRESSURE?
YES NO BLOOD DISORDERS?
YES NO EPILEPSY OR SEIZURES?
YES NO ALLERGIES, SINUS TROUBLE, OR HAY FEVER?
YES NO LUNG DISORDER (T.B., ASTHMA, EMPHYSEMA, OR OTHERS)?
YES NO KIDNEY DISORDER (NEPHRITIS, STONES, OR OTHERS)?
YES NO LIVER DISORDERS (HEPATITIS, CIRRHOSIS, JAUNDICE, OR OTHERS)?
YES NO VENEREAL DISEASE?
YES NO ARTHRITIS OR RHEUMATISM, ARTIFICIAL JOINT? WHERE? _____
YES NO STOMACH TROUBLE (ULCERS, COLITIS, OR OTHERS)?
YES NO EYE TROUBLE (GLAUCOMA OR OTHERS)?
YES NO RADIATION OR COBALT TREATMENT?
YES NO DIABETES?
YES NO IS ANYONE IN YOUR BLOOD RELATIVE FAMILY DIABETIC? RELATION? _____
YES NO OSTEOPOROSIS OR OSTEOPENIA?
IF SO, ARE YOU TAKING ANY MEDICATION? _____
YES NO HAVE YOU EVER BEEN TESTED FOR HIV/AIDS?
YES NO IF SO, HAVE YOU EVER TESTED POSITIVE?
YES NO DO YOU HAVE ANY CONDITION OR PROBLEM NOT LISTED ABOVE THAT YOU THINK WE SHOULD KNOW ABOUT?
EXPLAIN:

YES NO ARE YOU UNDER STRESS? *SOCIAL / BUSINESS / MARITAL / FINANCIAL*
YES NO DO YOU USE TOBACCO IN ANY FORM? *HOW MUCH?*_____*PER DAY*
YES NO HAVE YOU EXPERIENCED ANY UNFAVORABLE REACTIONS TO PREVIOUS DENTAL TREATMENT?
YES NO ARE YOU AWARE OF CLENCHING, GRITTING, OR GRINDING YOUR TEETH?
WHEN?
YES NO HAVE YOU EVER BEEN TREATED FOR PERIODONTAL DISEASE BEFORE?
WHEN AND BY WHOM?
YES NO ARE YOU TAKING ANY DRUGS OR MEDICATIONS?
PLEASE LIST:

WOMEN ONLY

YES NO ARE YOU TAKING ORAL CONTRACEPTIVES?
YES NO ARE YOU PREGNANT? YES NO HAVE YOU REACHED MENOPAUSE?

To the best of my knowledge, the above information is correct.

PATIENT'S SIGNATURE_____ DATE_____

OR IF A MINOR, SIGNATURE OF LEGAL GUARDIAN

THANK YOU