Fort Worth Periodontal Specialists

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PATIENT INFORMATION FORM

Date:_____

NAME_____NICKNAME_____

PHONE(CELL)_____PHONE(WK) _____PHONE (HM)_____

ADDRESS_____APT_____CITY_____ZIP CODE_____

S.S. #_____AGE_____D.O.B._____

PLACE OF EMPLOYMENT_____OCCUPATION_____

SPOUSE/PARENT NAME_____WORK NUMBER_____

S.S. #_____D.O.B._____

EMAIL_____

WHOM MAY WE CONTACT IN CASE OF AN EMERGENCY?_____PHONE_____

PHYSICIAN_____PHONE_____

GENERAL DENTIST_____PHONE_____

PHARMACY NAME_____PHONE_____

HOW DID YOU HEAR ABOUT OUR OFFICE?_____

DO YOU HAVE DENTAL INSURANCE? YES____NO___MEDICAL INSURANCE? YES___NO__

DENTAL HISTORY

CHIEF COMPLAINT_____

DO YOU:	YES	NO
HAVE PAIN IN YOUR MOUTH….....	____	____
WHERE_____		
HAVE SENSITVITY? HOT__COLD__ SWEET__		
HAVE FREQUENT HEADACHES……	____	____
HAVE POPPING OR CLICKING JOINTS IN FRONT OF YOUR EARS……	____	____
CLENCH OR GRIND TEETH.....	____	____
HAVE FREQUENT PROBLEMS WITH BAD BREATH……	____	____
USE TOBACOO PRODUCTS: WHICH AND HOW MUCH?_____		
DRINK ALCOHOL: HOW MUCH_____		
USE RECREATIONAL DRUGS?_____		
WHEN WERE YOU FIRST TOLD OF YOUR GUM PROBLEM_____		
AWARE OF ANY INFECTION	____	____

HAVE YOU:	YES	NO
HAD GUM SURGERY.....…….	____	____
HAD PERIODONTAL SCALING..……....	____	____
ARE YOU INTERESTED IN REPLACING MISSING TEETH	____	____
NOTICED BLEEDING GUMS WHEN YOU BRUSH……....	____	____
HAVE ANY TEETH SHIFT RECENTLY….....	____	____
HAD ORTHODONTICS (BRACES) …….....	____	____
EVER HAD A SERIOUS INJURY OR BLOW TO YOUR MOUTH……....	____	____
HAD YOUR WISDOM TEETH REMOVED	____	____
IF YES, WHEN_____		

DENTAL CARE

HOW OFTEN DO YOU HAVE DENTAL CLEANINGS AND CHECK-UPS_____

WHEN WAS YOUR LAST CLEANING?_____

WHEN WERE YOUR LAST XRAYS_____