DAVID BARACK D.D.S.

OLD ORCHARD PERIODONTICS & IMPLANT DENTISTRY, LTD.
PRACTICE LIMITED TO PERIODONTICS AND IMPLANT DENTISTRY

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DATE

ABOUT YOU

NAME

ADDRESS

CITY STATE ZIP

HOME PHONE

CELL PHONE

EMAIL

BIRTHDATE AGE MALE FEMALE

MARRIED SINGLE DIVORCED WIDOWED

SOCIAL SECURITY #

OCCUPATION

EMPLOYER

BUSINESS ADDRESS CITY

BUSINESS PHONE # / EXT

DDS THAT REFERRED YOU

PHYSICIAN'S NAME

STREET ADDRESS

CITY STATE ZIP

PHONE #

PERSON TO CONTACT FOR EMERGENCY

NAME

PHONE #

PHARMACY INFORMATION

NAME PHONE

STREET CITY

YOUR SPOUSE

NAME

OCCUPATION

EMPLOYER

BUSINESS ADDRESS

BUSINESS PHONE # / EXT

PRIMARY DENTAL INSURANCE CARRIER

EMPLOYEE NAME

COMPANY

INS ADDRESS

BIRTHDATE GROUP #

EMPLOYEE SSN OR ID #

SECOND DENTAL INSURANCE CARRIER

EMPLOYEE NAME

COMPANY

INS ADDRESS

BIRTHDATE GROUP #

EMPLOYEE SSN OR ID #

MEDICAL INSURANCE CARRIER

EMPLOYEE NAME

COMPANY

INS ADDRESS

BIRTHDATE GROUP #

EMPLOYEE SSN OR ID #

MEDICAL HISTORY

Welcome! So that we may provide you with the best possible care please complete this medical/dental history form. All information is completely confidential.

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ○ Yes ○ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ○ Yes ○ No If yes, please explain: _____
Are you taking any over the counter or natural medications? ○ Yes ○ No If yes, please explain: _____
Are you taking any vitamin supplements (i.e. fish oil, flax seed, omega 3)? ○ Yes ○ No If yes, please explain: _____
Are you on a special diet? ○ Yes ○ No If yes, please explain: _____
Do you take an aspirin daily? ○ Yes ○ No If yes, please explain: _____
Do you take medication for osteoporosis? ○ Yes ○ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ○ Yes ○ No If yes, please explain: _____
Do you use controlled substances? ○ Yes ○ No If yes, please explain: _____
Do you currently use or have you ever used tobacco? ○ Yes ○ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ○ Yes ○ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ○ Yes ○ No If yes, please explain: _____
Has it been recommended for you to pre-medicate before dental procedures? ○ Yes ○ No If yes, please explain: _____

Women: Are You
Pregnant/Trying to get pregnant? ○ Yes ○ No Taking oral contraceptives? ○ Yes ○ No Nursing? ○ Yes ○ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anestheics
☐ Other If yes, please explain:

AIDS/HIV Positive	○ Yes ○ No	Cortisone Medicine	○ Yes ○ No	Hemophilia	○ Yes ○ No	Recent Weight Loss	○Yes ○ No
Alzeimer's Disease	○ Yes ○ No	Diabetes	○ Yes ○ No	Hepatitis A	○ Yes ○ No	Renal Dialysis	○Yes ○ No
Anaphylaxis	○ Yes ○ No	Drug Addiction	○ Yes ○ No	Hepatitis B or C	○ Yes ○ No	Rheumatic Fever	○Yes ○ No
Anemia	○ Yes ○ No	Easily Winded	○ Yes ○ No	Herpes	○ Yes ○ No	Rheumatism	○Yes ○ No
Angina	○ Yes ○ No	Emphysema	○ Yes ○ No	High Blood Pressure	○ Yes ○ No	Scarlet Fever	○Yes ○ No
Arthritis	○ Yes ○ No	Epilepsy or Seizures	○ Yes ○ No	High Cholesterol	○ Yes ○ No	Shingles	○Yes ○ No
Gout	○ Yes ○ No	Excessive Bleeding	○ Yes ○ No	Hives or Rash	○ Yes ○ No	Sickle Cell Disease	○Yes ○ No
Artificial Heart Valve	○ Yes ○ No	Excessive Thirst	○ Yes ○ No	Hypoglycemia	○ Yes ○ No	Sinus Trouble	○Yes ○ No
Artificial Joint	○ Yes ○ No	Fainting Spells/Dizziness	○ Yes ○ No	Irregular Heartbeat	○ Yes ○ No	Spina Bifida	○Yes ○ No
Asthma	○ Yes ○ No	Frequent Cough	○ Yes ○ No	Kidney Problems	○ Yes ○ No	Stomach/Intestinal Disease	○Yes ○ No
Blood Disease	○ Yes ○ No	Frequent Diarrhea	○ Yes ○ No	Leukemia	○ Yes ○ No	Stroke	○Yes ○ No
Blood Transfusion	○ Yes ○ No	Frequent Headaches	○ Yes ○ No	Liver Disease	○ Yes ○ No	Swelling of Limbs	○Yes ○ No
Breathing Problem	○ Yes ○ No	Genital Herpes	○ Yes ○ No	Low Blood Pressure	○ Yes ○ No	Thyroid Disease	○Yes ○ No
Bruise Easily	○ Yes ○ No	Glaucoma	○ Yes ○ No	Lung Disease	○ Yes ○ No	Tonsilitis	○Yes ○ No
Cancer	○ Yes ○ No	Hay Fever	○ Yes ○ No	Mitral Valve Prolapse	○ Yes ○ No	Tuberculosis	○Yes ○ No
Chemotherapy	○ Yes ○ No	Heart Attack/Failure	○ Yes ○ No	Osteoporosis	○ Yes ○ No	Tumors or Growths	○Yes ○ No
Chest Pains	○ Yes ○ No	Heart Murmur	○ Yes ○ No	Pain in Jaw Joints	○ Yes ○ No	Ulcers	○Yes ○ No
Cold Sores/Fever Blisters	○ Yes ○ No	Heart Pace Maker	○ Yes ○ No	Parathryroid Disease	○ Yes ○ No	Venereal Disease	○Yes ○ No
Congenital Heart Disorder	○ Yes ○ No	Heart Trouble/Disease	○ Yes ○ No	Psychiatric Care	○ Yes ○ No	Yellow Jaundice	○Yes ○ No
Convulsions	○ Yes ○ No			Radiation Treatments	○ Yes ○ No		

Have you ever had any serious illness not listed above? ○ Yes ○ No If yes, please explain: _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN _____ DATE _____

DENTAL HISTORY

What is the reason for your visit today? _____

_____

Date of Last Visit _____ Last Dental Cleaning _____ Last Full Mouth X-rays _____

What was done at your last dental visit? _____

How often do you have dental examinations? _____

How often do you brush your teeth? _____ How often do you floss? _____

What other dental aids do you use? (Interplak, Proxabrush, etc.) _____

Do you have any dental problems now? ..... Yes _____ No _____

If yes, please describe: _____

_____

Are any of your teeth sensitive to:

Hot or Cold?	Yes	No
Sweets?	Yes	No
Biting or Chewing?	Yes	No
Have you noticed any mouth odors or bad tastes?	Yes	No
Do your gums bleed or hurt?	Yes	No
Have you noticed any loose teeth or changes in your bite?	Yes	No
Does food get caught in between your teeth?	Yes	No
If yes, where?	_____	
Do you have any teeth which are tender to biting pressure?	Yes	No
Have your teeth separated creating spaces between them?	Yes	No

Do you:

Clench or grind your teeth while awake or asleep?	Yes	No
Mouth breathe while awake or asleep?	Yes	No
Smoke/Chew tobacco?	Yes	No
If yes, how much?	_____	
How long?	_____	
Do you drink some form of alcohol daily?	Yes	No

Have you ever had:

Orthodontic treatment?	Yes	No
Oral surgery?	Yes	No
Periodontal treatment?	Yes	No
If so, when?		

_____

_____

Have you had your teeth grounded or the bite adjusted?	Yes	No
A bite plate or mouth guard?	Yes	No
A serious injury to the mouth or head?	Yes	No
If so, describe, including cause:		

_____

_____

Have you experienced?

Clicking or popping of the jaw?	Yes	No
Do you awaken with pain near your ears or jaw muscles?	Yes	No
Headaches, neck aches or shoulder aches?	Yes	No
Sore muscles (neck, shoulders)?	Yes	No
A bite that feels uncomfortable or unusual?	Yes	No
Pain? (joint, ear, side of face)	Yes	No
Do you feel nervous about having dental treatment?	Yes	No