Sierra Nevada
Periodontics & Implant Dentistry

PATIENT INFORMATION FORM

Name_____ Date of Birth_____ Male/Female
Physical address_____ City_____ State_____ Zip_____
Mailing address_____ City_____ State_____ Zip_____
Marital Status: S M W D Soc. Sec. # of Patient_____
Home phone_____ Cell phone_____ Work phone_____Ext_____
Please circle best contact #
Email address_____
Parent name (if minor patient) _____ Soc. Sec. #_____ DOB_____
Primary Dental Insurance_____ Insured name_____
Relationship of Insured Person to Patient_____
Soc. Sec. # of Insured_____ DOB of Insured_____
Employer_____Occupation_____
Secondary Dental Insurance _____ Insured name_____
Relationship of Insured Person to Patient_____ Soc. Sec. # of Insured_____
DOB of Insured_____ Employer_____Occupation_____
Referring Dentist_____City_____
General Dentist _____ City_____
Physician_____ City_____ Date of last physical exam_____
Preferred Pharmacy Name & Location_____

Oral/Dental History

1. When were your teeth last cleaned?_____ How long before that?_____
2. How often do you brush your teeth?_____ What times of the day?_____
3. Do you use: ( ) hand toothbrush ( ) electric toothbrush If electric, please circle type: Sonicare, Oral B
4. Are your toothbrush bristles ( ) soft ( ) medium ( ) hard
5. Do you use anything to clean between your teeth? If yes, please list_____
6. Are your teeth sensitive? If yes, to what?_____
7. Have you ever had braces? If yes, when and for how long?_____
8. Have you ever had a deep cleaning?_____ Gum surgery?_____

Medical History

1. Are you required to take antibiotics before dental procedures? Y N
2. Height: Feet____ Inches_____ Weight (lbs)_____ How is your general health: Good Fair Poor
3. Are you now being treated or have you been treated within the last year by a physician? Y N

_____

_____

_____

Please turn over and complete other side

4. Surgeries and approximate dates of those surgeries:
   _____
   _____

5. Please list any prescribed medications, over-the-counter medications or herbal supplements that you take:_____
   _____
   _____

6. Have you ever taken medication for bone density or osteoporosis?_____ If yes, when?_____
   Name of medication_____

7. Have you ever had an allergic reaction to any of the following?
   Aspirin Y N Codeine Y N Dental Anesthetics (Novocaine/Lidocaine) Y N
   Penicillin Y N Sleeping Pills Y N Other Drugs_____

8. Have you ever tested positive for HIV? Y N

9. Have you ever had:

Heart trouble_____	Y N	Hepatitis (liver disease)_____	Y N
Heart attack_____	Y N	Thyroid or parathyroid disease_____	Y N
Heart murmur_____	Y N	Epilepsy/Convulsions_____	Y N
High blood pressure_____	Y N	Lung disease_____	Y N
A Stroke_____	Y N	Asthma_____	Y N
Rheumatic fever_____	Y N	Tuberculosis_____	Y N
Cancer_____	Y N	Kidney disease_____	Y N
Radiation treatment_____	Y N	Ulcers_____	Y N
Chemotherapy_____	Y N	Gastrointestinal Disorder_____	Y N
Diabetes (sugar in blood)_____	Y N	Venereal Disease/STDs_____	Y N
Bleeding problems_____	Y N	Autoimmune diseases_____	Y N
Anemia or abnormal blood counts_____	Y N	Anxiety/Depression_____	Y N

Other disorders not listed_____

10. Do you smoke cigarettes?_____ If yes, how many per day?_____ For how long?_____
11. Do you chew tobacco?_____ If yes, how much?_____ For how long?_____
12. Do you consume any marijuana products?_____ If yes, what?_____ How often?_____
13. Does dental work make you nervous?_____
14. Do you require or desire sedation for dental work? Yes_____ No_____

For Women Only:

Are you currently taking birth control pills?_____

Are you pregnant?_____ If yes, what month?_____

Are you nursing?_____

Should this account become delinquent, I understand that I will be responsible for all reasonable costs of collection.

Initials_____

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

Patient Signature_____ **Date**_____