David Goteiner, DDS, LLC

Practice limited to periodontics Spec #2218 • Oral medicine • Dental implants

IN ORDER TO HELP RENDER THE PROPER DENTAL SERVICES TO YOU, PLEASE BE KIND ENOUGH TO ANSWER THE FOLLOWING QUESTIONS PLEASE NOTE THERE IS ROOM FOR CLARIFICATION AND ANY OTHER INFORMATION YOU THINK WE SHOULD HAVE. THANK YOU FOR YOUR COOPERATION.

Name_____ Date of Birth_____
Address_____City_____Zip code_____
Home Phone_____Work Phone_____Cell Phone_____
In case of emergency, whom should we contact? _____Phone#_____
Dentist_____ Physician_____Date of Last Visit to MD_____
Employer_____ Social Security No._____
Dental Insurance_____ SS# of the Insured_____
Insured's Name_____ Insured's Date of Birth_____
Insurance ID#_____Do you have secondary insurance? Yes ☐ **No** ☐

MAY WE LEAVE MESSAGES ON YOUR HOME PHONE? **Yes** ☐ **No** ☐

MAY WE CONTACT YOU BY EMAIL?_____@_____

MEDICAL HEALTH

If you are taking medications, herbs or supplements now, please tell us which ones and why._____
_____
Do you have allergies?___ To what? _____
Have you ever had an operation, radiation or chemotherapy? _____
Have you ever been hospitalized and why? _____
Have you ever been seriously ill? _____
Do you have osteoporosis?_____ If yes what medication are you taking?_____
Yes ☐ **No** ☐ Do you have asthma? Sleeping problems? Sleep Apnea or trouble sleeping? **Yes** ☐ **No** ☐
Yes ☐ Do you have any artificial joints? **No** ☐ Do you have problems with the joint? _____
Yes ☐ Do you have heart problems? **No** ☐ pacemaker **No** ☐
Yes ☐ Has a physician requested antibiotic coverage (Premedication) before dental visits? **No** ☐
Yes ☐ Do you have anemia? **No** ☐
Yes ☐ Do you have high or low blood pressure? **No** ☐
Yes ☐ Do you have numbness, tingling or swelling anywhere? **No** ☐
Yes ☐ Do you have arthritis? **No** ☐ Where? _____
Yes ☐ **No** ☐ Do have diabetes? How are you treating it?_____
Do you have fainting spells, seizures, or recurrent headaches?_____ **Yes** ☐ **No** ☐
Have you ever had liver trouble, hepatitis, or jaundice? _____**Yes** ☐ **No** ☐
Have you ever been treated for kidney or bladder problems?_____**Yes** ☐ **No** ☐
Have you ever had hives, skin diseases or skin rashes? _____**Yes** ☐ **No** ☐
Have you ever been treated for stomach problems such as ulcers**?** _____**Yes** ☐ **No** ☐
Are you on a special diet? **Yes** ☐ **No** ☐ Has your weight changed recently?_____ **Yes** ☐ **No** ☐
Yes ☐ **No** ☐ Do you bruise easily, or bleed excessively after tooth extractions?
Yes ☐ **No** ☐Are you HIV positive?
Yes ☐ **No** ☐ Do you smoke? _____ How much? _____
Is there anything we have not asked you? _____

THIS SECTION IS FOR WOMEN ONLY

Is your menstrual cycle regular? **Yes** ☐ **No** ☐
Are you on the "pill?" **Yes** ☐ **No** ☐
Are you pregnant? **Yes** ☐ **No** ☐

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DENTAL HEALTH

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Reason for this visit_____
Who can we thank for referring you? _____
Yes ☐ **No** ☐ Are you having dental pain? Where_____
If so, how long have you noticed it? _____
Is it sharp__, dull__, constant__, intermittent__, Aggravated by hot__, cold__, pressure on chewing__
Yes ☐ **No** ☐ Do you frequently have canker sores, painful gums, or a burning sensation in your mouth?
Yes ☐ **No** ☐ Do your gums ever bleed? If so, when? _____
When did you last have your teeth cleaned? _____
Where? _____
How frequently have you had your teeth cleaned in the last 10 years? _____
Yes ☐ **No** ☐ Do you have any teeth, which seem to have become loose or have recently shifted position?
Yes ☐ **No** ☐ Have you noticed bad breath or bad taste from your mouth?
Yes ☐ **No** ☐ Have you ever had gum boils and if so when? _____
Yes ☐ **No** ☐ Have you ever had Vincent's Infection (Trench Mouth) and if so when? _____
Have you ever had periodontal treatment before? **Yes** ☐ **No** ☐ When? _____ Who? _____
Have you ever had orthodontic treatment? **Yes** ☐ **No** ☐ When? _____
Indicate approximately the date of your last tooth extraction _____
Yes ☐ **No** ☐ Did you need any medication before or after the extraction?
Yes ☐ **No** ☐ Was there any problem with bleeding, pain, or healing after the extraction?
Yes ☐ **No** ☐ Do you avoid brushing any part of your mouth because of pain?
If yes, what part? _____
Do you feel twinges of pain when your teeth come in contact with:

a) Hot foods or liquids, i.e., soup, coffee, tea, etc? **Yes** ☐ **No** ☐
b) Cold foods or liquids, i.e., ice cream, cold fruit, etc? **Yes** ☐ **No** ☐
c) Sweets, i.e., candy, fruit, sweet desserts, etc? **Yes** ☐ **No** ☐
d) Sours, i.e., lemons, limes, grapefruit, etc? **Yes** ☐ **No** ☐

Does food tend to wedge between any of your teeth? **Yes** ☐ **No** ☐
Does your jaw ever click when you chew? Is there pain? **Yes** ☐ **No** ☐
☐ **Yes** **No** ☐ Do you clench, grit, or grind your teeth? If so, when?_____
Do you have any habits such as biting your nails, chewing on a pencil or pipe? **Yes** ☐ **No** ☐
How often do you brush your teeth daily? _____
Please circle: Do you routinely use dental floss, rubber tip, stimudents, water pik, or electric toothbrush?
Are you presently dissatisfied with the appearance of your teeth? **Yes** ☐ **No** ☐
Explain: _____
Are you worried about undertaking periodontal treatment? **Yes** ☐ **No** ☐
Please add any additional information that you feel may be helpful or important in diagnosing and treating your condition.

_____
_____
_____
_____
_____

Rev 02/10

Signature_____ Date:_____